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The 1967-68 mental health services (MHS) program in the Pittsburgh public school system, number of children served, studies undertaken, and other staff activities are considered. A research study of perceptual-motor dysfunction among emotionally disturbed, educable mentally handicapped, and normal children, and two perceptual surveys developed for identification are described. An analysis is presented of the effectiveness of psychiatric consultation with the staff of Project Upward Bound. Corporal punishment in the schools and some alternatives to it are discussed in terms of historical development, various community rules, and other methods of discipline. Consideration is given to nonachievers, the interdisciplinary approach of the MHS program, and to case reports illustrating the lack of adequate community facilities for the disturbed. (RJ)

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MENTAL HEALTH SERVICES

1968 REPORT

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MENTAL HEALTH SERVICES IN THE PITTSBURGH PUBLIC SCHOOLS

1967-1968

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Pittsburgh Public Schools
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July 1968

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PREFACE

Brief Report to the Board of Public Education

Stonewall B. Stickney, M.D.,
Director, Mental Health Services
Pittsburgh Public Schools

The Mental Health Services are completing their third year of operation and the time has come to review what has been learned and accomplished.

We have learned that the mental health role or the therapeutic task assigned to the schools is far greater than any school system realizes, and has grown to almost equal importance with the academic tasks of the schools. Unless we meet the mental health challenge, thousands of children will never be reached academically.

The school is important in providing mental health services for children because nobody else has, for 95 percent of the children needing help, or will. Nobody else can do it as well, given the proper help. Nobody else has the opportunity for prevention plus building in strengths. No other institution outside the family has such a long-term, daily commitment to children, or is so able to identify the needy child. No other agency has the social leverage of the schools to get help for a child, even when parents and community are ignoring the need for help.

We have also learned what the schools need to perform this mental health mission. They must be able to provide speedy response to requests for crisis consultation. Over 700 referrals were handled in 1966-1967 and more than 1200 in 1967-1968. There have been special class programs for emotionally disturbed children, nine adjustment classes and six resource rooms, plus medical sanction for exclusion of children who need residential care, and for whom placement in the adjustment class or resource room programs is not enough.

There has been some in-service education in mental health principles for teachers and administrators. In one year, half of the vice principals, all elementary instructional supervisors, all pre-primary teachers, many kindergarten teachers and a few elementary school faculties participated in such seminars. This is the heart of the MHS program and must be expanded and strengthened.

Early preventive efforts include a research study of perceptual-motor dysfunction among normal, retarded and disturbed children which validated two diagnostic instruments and revealed incidence rates in these populations. Further screening of children, for perceptual-motor dysfunction, is planned. An investigation of the efficacy of treatment for these children is being developed through the establishment of a Learning Disability Habilitation Program.

A study is being made of the mental health needs of children from pre-primary classes through grade two. We hope to use the Sumpter Child Study Project as a model to screen all children before first grade.

Perhaps the most we have accomplished, aside from a great deal of service, is the development of a philosophy, a style, and methods that grow from necessity. This model is now widely known. Reprints have been requested 54 times from 22 states, and 11 more requests were received from foreign countries. About 100 talks, given in 15 states, have described the Mental Health Services in the Pittsburgh Public Schools. Response has been uniformly enthusiastic.

In the future, I think the unique aspect will be seen to be the central, administrative, full-time character of your use of the chief psychiatric consultant. No other system has it. This brings priorities to light in the schools and in the community, and leads to a coherent philosophy.

We have met no widespread resistance. This year, we have served 71 of 88 elementary schools and twenty of twenty-one high schools. Coverage has been thin, by the same token, and Mental Health Services must have a larger staff.

Every element of our program depends heavily on the retrieval of information from teachers, and upon the use of teachers as natural therapeutic aides. The difficulty has been in freeing them for conferences and seminars. Volunteers and parents can help, to a limited extent, as they have at Wightman Elementary School. A stable corps of six to eight regular substitutes, attached to MHS, is needed. Without this help, every element of the MHS program will be weakened.

The "puzzle of child care", involving such community agencies as Juvenile Court, Child Welfare Services and other custodial and treatment facilities, must be resolved. All welfare and treatment agencies expect the Pittsburgh Public Schools to be the custodian of severely disturbed and severely anti-social children...they haven't the space, so they expect the schools to furnish day-care. Often, by acquiescing, the schools unwittingly conspire to keep a child in a destructive and pathogenic home.

The schools' best defense against this imposition is to have MHS meet regularly with representatives of the agencies and state our custodial limits. A firm medical excusal ~~is~~ the final best defense. MHS has used the medical excusal in only one to three percent of children referred. Even this small number has stimulated treatment agencies, Child Welfare Services, and Juvenile Court to protest. They say MHS is "finding too many cases!" We can't avoid finding cases.

Like the rest of the system, there is so much we could do, and so little to do it with. If the School District would invest more in MHS, it could be reimbursed by the Department of Public Instruction, especially in the area that overlaps with Special Education.

The Maurice Falk Medical Fund not only gave us the funds to get started, but Philip Hallen, their president, has offered constant support and information, and has provided an entree to many valuable professional people and organizations, locally and nationally.

Further, he has encouraged us to continue some important research in prevention, and offered funds to help it get started. This is the Rosner-Richman project for perceptual-motor learning problems, the Learning Disability Habilitation Program. We are persuaded that this kind of study, whose aim is to prevent school failure, is the best available approach to the prevention of later failure in life.

Recommendations

Mental Health Services is a good patch-up program with a clear philosophy that can be used in other cities. But it will never reach its potential unless it moves toward PREVENTION. This will mean:

a. In-service training in mental health, especially for elementary teachers

b. Diagnostic screening of all children before first grade

c. The expansion of Special Education services for the remedy of what disorders we find

d. A panel system for dealing with disturbed teachers. To date, the Pittsburgh Public Schools, like nearly all school systems, has done nothing about emotionally disturbed teachers and administrators. Our current system is ineffectual, and, in practice, it is now the community that forces action in such cases. The Pittsburgh Public Schools need a review panel composed of educators, lawyers, and mental health professionals. They should be paid from outside the school system, so no conflict of interest would arise. Along with this, the insurance and retirement plans should be greatly expanded so that an educator who must have psychiatric care or even must be removed from teaching, will not be penalized.

We will need to have:

a. The corps of regular substitutes to free teachers to attend conferences and seminars

b. More psychiatric consultant time, e.g., at least another besides my replacement

c. Three or four more social workers.

If the Pittsburgh Public Schools expect to attract psychiatric consultants to do this vital work, it must somehow meet the local competition in salaries, and, just as important, offer much more opportunity for psychiatrists to teach our teachers.

In view of the growing mental health role of schools, the Board should offer two ample hearings per school year for the MHS to outline its progress and its difficulties.

No small part of those hearings should be the evaluations of the program, especially in its research aspects, by the MHS Research Associate. In the long run, the value of the program will be demonstrated or not by this most valuable aspect of its functions.

Our Research Associate has done a full-time job on a half-time schedule. The program will be fortunate to have her services, full-time, next year, and the early indications are that the forthcoming research will be a major breakthrough in the prevention of school failure. This may well be our best and clearest approach to the prevention of later vocational and social failure.

June 1968.

MENTAL HEALTH SERVICES IN THE PITTSBURGH PUBLIC SCHOOLS

1967-1968

The program of the Division of Mental Health Services during the 1967-1968 school year continued, generally, along the lines described and analyzed in the two previous Evaluation Reports (Richman, 1966; Richman, 1967). There were some changes and additions which occurred during the current year.

The adjustment class which had been established at Philip Murray Elementary School was transferred to Whittier Elementary School when Philip Murray experienced an unexpected rise in attendance and needed the space for regular classes. An arrangement was made between the Board of Public Education and Pressley House, a residential psychiatric institution for children, so that the Division of Mental Health Services would provide monthly consultation services to their two elementary school classes. The resource room at South High School was not re-opened this year, but a new resource room was developed in Columbus Middle School in January 1968. Two new adjustment classes were established; one at Baxter Elementary School and one at Belmar Elementary School.

This brought the number of adjustment classes to eleven and the number of resource rooms to six. The adjustment class program in the elementary schools served 141 children, and the resource room program in the secondary schools served 236 children. In all, 377 children used the special class program, formally or informally. Although many of them were assigned to full-time participation in the program, by the end of the 1967-1968 school year, all of them had returned to regular classes, at least on a part-time basis.

The tables on the following page indicate the size and location of the classes.

Table 1. Adjustment Class Programs

Arsenal	15
Baxter	15
Belmar	11
Colfax	9
Conroy	31
Friendship	9
Holmes	9
Pressley House (two classes)	19
Weil	16
Whittier	7
Total	141

Table 2. Resource Room Programs

Columbus	14
Fifth Avenue	20
Gladstone	23
Latimer	29
Schenley	46
Westinghouse	104
Total	236

Of the 225 children in the adjustment class and resource room program during the 1966-1967 school year, 147 (65 percent) have returned to regular classes. Thirty-two of the elementary school children and twenty-eight of the secondary school students have continued using the adjustment class and resource room program during the current year, all on a part-time basis.

The remaining 78 children (35 percent) can be accounted for as follows:

Withdrew from school	28
Medical excusal (CA-31)	15
Transferred	13
Moved out of district	5
Juvenile Court placement	5
Child Welfare Services placement	4
Hospitalization	3
Home for Crippled Children placement	3
Special Education transfer	1
Graduated	1
Total	78

To meet the needs of the expanded program, an additional part-time psychiatrist and a full-time social worker joined the Mental Health Services staff in September 1967. For the current school year, therefore, the MHS staff consisted of a Psychiatrist-Director, a Program Coordinator, two part-time psychiatric consultants, four full-time social workers and a part-time Research Associate.

The total number of referrals received and acted upon by the Division of Mental Health Services for 1967-1968 was 1,266.

Perceptual-Motor Development Study

During the 1966-1967 school year, it had been noted that 31 percent of the elementary school children referred to the Mental Health Services were believed to have some perceptual-motor dysfunction. On the basis of this finding, an optometrist with considerable experience in the field of perceptual-motor development, joined the staff in October 1967, as a part-time consultant.

Two diagnostic screening instruments, the Rosner Perceptual Survey and the Rosner-Richman Perceptual Survey, were developed and used in a study of perceptual-motor dysfunction among emotionally disturbed, normal and educable mentally retarded children in the Pittsburgh Public Schools.

It was found that approximately 13 percent of the children from regular classes, 68 percent of those in adjustment classes and 89 percent of the educable retardates demonstrated perceptual-motor dysfunction. A detailed report of the research is published separately.

Planning has begun to develop a pilot remediation program to measure the effectiveness of perceptual-motor development training for the children who were identified. This work will be carried out during the 1968-1969 school year, supported by a special grant from the Maurice Falk Medical Fund.

Project Upward Bound

The Director of the Division of Mental Health Services continued to provide consultation services to Project Upward Bound, a program designed to provide special help for the able, disadvantaged student who is not achieving up to his potential. Participants include students from various Pittsburgh high schools, and the staff consists of teachers, social workers and counselors. Psychiatric consultation occurred on a regularly scheduled bi-weekly basis and centered around specific students who were the cause of staff concern.

Because the style of consultation with the school personnel involved in Project Upward Bound is essentially the same as that used regularly in the Mental Health Services program in the Pittsburgh Public

Schools, it was believed that an examination and evaluation of this activity would have relevance to school consultation practice in general.

The findings indicated that the contribution of the psychiatric consultant proved to be effective and valuable. The consultation conferences were fulfilling their objectives, meeting the needs of the Project Upward Bound staff, and were being received enthusiastically. Details of the research are published in a separate report.

Pre-Primary Study

In an effort to design a preventive mental health program component, a study was begun to survey the mental health needs of the pre-primary children (three and four years old) in the Pittsburgh Public Schools. A questionnaire was developed and sent to the 58 pre-primary teachers, asking for referrals of children about whom they were concerned. Twenty-five teachers responded with more than 200 referrals. The survey will be continued in the 1968-1969 school year and the Mental Health Services staff will provide consultation services for the emotionally disturbed children who will have been identified.

Explorations are being made to extend the study through collaboration with the Graduate School of Public Health of the University of Pittsburgh.

It is the position of the Division of Mental Health Services that the development of a pre-primary or pre-kindergarten screening program for the early identification of all exceptional children is imperative if any preventive work is to be done by the schools. A large part of next year's effort will be aimed in this direction.

In-Service Education

Seminars for school personnel, centering around mental health concepts and principles, were conducted with pre-primary teachers, and the elementary school faculties at Wightman, Davis, Linden and Regent Square Elementary Schools, at the request of the principals. Informal feedback from the participants indicate that they perceived the seminars as valuable experiences for themselves.

It is strongly felt by Mental Health Services that the continuing education of school personnel in mental health must command a large part of their time and attention, and there will be a continuing effort in this direction.

Student Internships

During the 1967-1968 school year, two student teachers and two graduate interns from the Department of Special Education, University of Pittsburgh, were placed in adjustment classes and a resource room. Two graduate students from the Department of Special Education, Penn State University, were assigned to the Central Office staff of the Division of Mental Health Services.

The Division also provided field placements for four students from the Graduate School of Social Work, University of Pittsburgh. A graduate intern from the Department of Educational Research was assigned to the Perceptual-Motor Development study, and a student from the University of Pittsburgh Medical School was assisted in carrying out a follow-up study of some of the students who had been served by the Division of Mental Health Services. In all, twelve graduate students were provided with training and supervision by the Division.

The Committee on Corporal Punishment

The Director of the Division of Mental Health Services served as a member of a special Board of Education committee charged with reviewing current policy regarding the use of corporal punishment in the schools. The committee met with concerned members of the community and school officials, and considered recommendations for changes

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Community Activities

Several meetings were held concerning the scarcity or absence of child care services in the community. Participants included MHS staff members, State legislators and a number of mental health professionals in the community.

A report was written, titled "While Rome Burns...", which documented the plight of disturbed, dependent and neglected children for whom little or no service or treatment is available. It has become obvious that the schools cannot continue to function as inappropriate custodians of many of these children, and that community action is urgently needed.

The Division of Mental Health Services will continue to collaborate with community agencies in efforts to stimulate, encourage and participate in such actions.

Speeches and Consultations

The Director of Mental Health Services devoted some of his time to communication with other mental health professionals around the country. The list below is a record of some of those activities.

New Mental Health program	Altoona, Pa.
County Mental Health program	Allegheny County, Pa.
Elementary Principals' seminar	Pittsburgh, Pa.
Mental Health Association	Westport, N.Y.
School Social Workers	Pittsburgh, Pa.
International Association of Pupil Personnel Workers	Philadelphia, Pa.
American Association of Women Deans and Counselors	Pittsburgh, Pa.

Pennsylvania Mental Health, Inc.	Pittsburgh, Pa.
Mental Health staff	Butler, Pa.
Project Re-Ed	Nashville, Tenn.
Forest Hospital	Chicago, Ill.
Mental Health Association	South Carolina
Joint Conference on Childhood Mental Health and Illness	New York
Principals' Association	Chicago, Ill.
American Orthopsychiatric Association	Chicago, Ill.
Girls' Service Club staff	Pittsburgh, Pa.
Mental Health Association	Poughkeepsie, N. Y.
Mental Health Association	Huntsville, Ala.
Mental Health Association	Birmingham, Ala.
Duquesne University	Pittsburgh, Pa.

In addition, on the local level, he has provided consultation services to the Department of Education, Carnegie-Mellon University, Primary Education Project, Head Start, Home for Crippled Children, Pace School, and the new Community Mental Health programs at St. Francis Hospital, Western Psychiatric Institute and Clinic, and Allegheny General Hospital.

MHS staff presented papers at the National Conference on Social Welfare, Pennsylvania State Convention of the Council for Exceptional Children, International Convention of the Council for Exceptional Children, and made many speeches for the PTA Council and other local organizations.

Response from the groups listed above confirmed the belief that the MHS program represents an important and unique approach to school mental health. Considering that the MHS staff has been composed of only six full-time and four part-time professionals, the volume and quality of activity has been impressive.

The commitment of the Board of Public Education, the generosity of the Maurice Falk Medical Fund, and the dedication of the MHS staff have all contributed to the development of new services to help the troubled children in our schools. The dynamic and imaginative leadership provided by the Director during the past three years has been a major force in the creation and implementation of the program. His vision, his boundless energy and wit, his concern and respect for all people have helped to shape the philosophy and the activities of the Division of Mental Health Services in the Pittsburgh Public Schools.

A STUDY OF PERCEPTUAL-MOTOR DYSFUNCTION AMONG EMOTIONALLY DISTURBED, EDUCABLE MENTALLY RETARDED AND NORMAL CHILDREN IN THE PITTSBURGH PUBLIC SCHOOLS

Vivien Richman, M. Ed.,
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Jerome Rosner, O.D.,
Consultant,

and

Russell H. Scott, Ph. D.,
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Division of Mental Health Services
Pittsburgh Public Schools

Stonewall B. Stickney, M.D., Director
George J. Wilson, Coordinator

July 1968

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Appendix

I. Introduction

The problem of children who are not learning in school has received considerable attention in this country during the last decade. (Havighurst, 1967; Kessler, 1966). There was a time when children with school problems were thought of as being "bad" and were punished accordingly. Others may have been regarded as being lazy or uncommitted to learning, and attention was given to increasing their motivation. Recent evidence collected by Vinter and Sarri (Thomas, 1967) demonstrated, however, that this was not the case. Non-achievers were not lacking in motivation, but in skills.

With the rise in age of compulsory school attendance, the school has been legally bound to contain and educate the children in the community, with a few legal exceptions, usually until they reach the age of sixteen or seventeen. Further, the school requires that all the children internalize and pursue the goal of academic success, and conform to some standards of conduct. (Schafer, 1967).

Depending on the theoretical orientation from which the problem is viewed, the children who do not learn may be classified in a variety of ways: emotionally disturbed, disadvantaged or culturally deprived, socially maladjusted, neurologically handicapped, educationally handicapped, children with minimal brain damage, with perceptual-motor dysfunction, or with learning disabilities. If these children, as a result of their unsuccessful careers in learning develop other socially undesirable behavior, they may also be classified as truants, drop-outs, delinquents and unemployables.

How a problem is defined, by whom, and according to which theoretical orientation, then, will determine the treatment prescribed, and how and by whom it will be administered. The chart which follows will illustrate the range of different treatments available for dealing with the child who does not learn. It can be seen easily that the definition of the problem, the identifying category in which it is placed, and the underlying theoretical orientation will determine, to a large degree, the nature of the treatment and the professional personnel required to administer it.

Although the teacher is involved as a part of the treatment in most of the categories on the chart, his role and function are bound to be affected by the theoretical emphasis of the program.

b-3.

Identifying Category	Theoretical Orientation	Treatment	Source of Treatment
Emotionally disturbed	Psychiatry, psychology, psychiatric social work	Psychoanalysis, psychotherapy, case work	Psychiatrist, psychologist, social worker, teacher
Disadvantaged, culturally deprived	Sociology, educational sociology, community organization, education	Social change, compensatory education, curriculum changes	Sociologist, community organizer, school personnel
Socially maladjusted	Social work, group dynamics	Group work, case work, counselling	Social worker, guidance counselor, teacher
Neurologically handicapped, minimal brain damage	Neurology, medicine, special education	Medication, physiotherapy, special teaching techniques	Neurologist, physician, physiatrist, special teacher
Perceptual-motor dysfunction	Child development, perceptual development theories, optometry	Prescribed remedial techniques to improve perception	Optometrist, perceptual-motor development consultant, technician, teacher
Educationally handicapped	Education, learning theory	Remedial teaching techniques, equipment and material	Special remedial teacher

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Identifying Category	Theoretical Orientation	Treatment	Source of Treatment
Learning disability	Multi-discipline approach: education, social work, preventive psychiatry, psychology, learning theory	Re-training or re-education, teaching the child to learn how to learn	Team: psychiatric and social work consultants, teacher, psychologist, school social worker, counselor, others
Truant, drop-out	School social work, law	Case work, counseling, legal sanctions	School social worker, counselor, court worker
Delinquent	Law, social work	Referral to correctional institution, probation, case work	Legal personnel, correctional personnel, social worker
Unemployable	Economics, social work	Welfare, re-training	Public assistance, teacher

Sometimes, by attaching a diagnostic classification to a group of non-learning children, the illusions are created that, by so labeling them, they are now homogeneous groups and that the problem has been adequately dealt with. In reality, it may be that a child who was diagnosed as being "emotionally disturbed" may possibly belong in the disadvantaged, neurologically handicapped, socially maladjusted, or any other of the groups named.

One of the contributing difficulties arises from the variety of disciplines and professions which have been concerned about the child who does not learn. Neurologists, pediatricians, child development theorists, ophthamologists, optometrists, psychologists, speech and hearing therapists, psychiatrists, otologists, sociologists, as well as educators, have introduced terminology from their own fields into the literature to describe the disabled learner. Johnson and Myklebust (1967) provide an exhaustive review of the descriptive terms which have been used throughout this century to classify him.

An Operational Definition

Barsch (1968) has written:

> "Learning disability is a phenomenon of learning cutting across all ages and all populations. It is to be found at all levels where individuals must learn. It is a term to be applied to any learner who fails to benefit from an existing curriculum into which he has been placed (pp. 13-14)."

In more specific terms, one or more of the following characteristics may be noted: hyperactivity, distractibility, impulsivity, poor motor coordination, perseveration, short attention span, and poor performance on psychological tests of perception. (Capobianco, 1964). Some of the more commonly noted behavioral correlates are: reversal of letters or words in reading or writing, lack of hand preference, indistinct speech, difficulty in relating to time and series sequences, illegible handwriting, confused spatial orientation, problems of laterality and directionality, memory disorders, and impaired auditory and visual perception. These symptoms rarely appear in isolation. (Myklebust & Johnson, 1962).

Children with learning disabilities, cognitive-motor deficits or perceptual-motor dysfunction have been described by Braun and others (1967) as being overly aggressive, or very withdrawn, with a low tolerance for frustration.

> "Academically, these children frequently have difficulty in learning to read, write and do number work. They may have illegible handwriting, reverse letters, numbers and words. In addition, they may have difficulties in the following: transferring information from the chalkboard to seat work, shifting their eyes from left to right for reading, recognizing simple objects and their relationships to each other in space, differentiating sounds that are similar, following verbal directions in the classroom and expressing their thoughts in words (pp. 1-2)."

The school frequently views these children as behavior or discipline problems. It has been estimated that the incidence of perceptual-motor dysfunction among school children ranges from 11 to 20 percent. (Wunderlich, 1968).

II. Review of the Literature

The importance of perceptual-motor development and sensory training in relation to learning has long been recognized. In 1799, Jean Itard (1932) recorded his work with Victor, the "Wild Boy of Aveyron." He was followed by Seguin (1907) who, similarly, developed and used a sequential program of sensory training with severely retarded, or possibly, brain injured subjects.

The work of Maria Montessori (1939) further developed and refined the theories and techniques of her predecessors, as she worked, first, with retarded children and later, with the disadvantaged slum children of Rome.

Contributions to the development of theories of perceptual development have come from the fields of neurology (Orton, 1937; Ozer, 1968) and optometry (Rosner, 1966; Coleman, 1968), as well as psychology, learning theory, and child development.

The development of cognitive and perceptual processes in the child has been examined and postulated by Gesell (1925), Piaget (1950, 1952), Kephart (1960), and Hull and Osgood (Weener, Barritt & Semmel, 1967). The work of Piaget (Flavell, 1963), in particular, suggests that the order or sequence of the development of cognitive functions is unvarying. He presents a rationale to demonstrate that the achievements of a particular period are dependent upon those which preceded them. It is suggested that if the experience of the child has been seriously restricted, the child's intellectual resources may be expected to be limited too.

The child's earliest observable responses to sensory experiences are motor and affective. He may respond visibly with various positive and negative feeling tones, which may not be explicitly identifiable, but are not bland and uniform. Beginning with unintentional or reflex actions, he rapidly learns to coordinate his activities with his sensations, preparing him for later purposeful action. It is through these early sensory-motor explorations that the child is first able to construct his reality.

He learns to differentiate and integrate movements of his own body. For example, he differentiates elbow and wrist movements and one arm from the other, and, through an integrative processing of patterns, to control his fingers. (Kephart, 1960). He learns that his environment is not part of him, although his world is still an egocentric one.

A child who does not progress normally through this period may feel himself as one with the space around him, rather than as a distinct entity. (Jansky, 1961). Such a child lacks a true conception of his own body image. The foundation upon which laterality and directionality are built is faulty or missing. This has serious implications for reading, writing, following directions, coordination, and many other tasks which he will eventually be asked to perform. (Bender, 1956).

There is a gradual transformation in the child from a direct-action approach, in the exploration of his world, to the development of "images" of action. During the early stages of development, the child must see an object in order to know that it exists. Gradually, he learns to recognize that it exists even when it is not in view. The manipulation of this imagery allows the beginning of elementary problem-solving and simple conceptualization. Symbolic representation originates in the imaginal translation of action. The development of this ability provides the child with a broader scope in dealing with reality than through direct action alone, and provides the basis for more intelligent behavior. Language, as it develops, permits an even greater extension of the child's intellectual capacities and provides a symbolic medium for thought.

Children who have problems in imagery may be unable to recall details of the sights and sounds of their every-day life, or to attach meaning to the expressions and gestures of others. (Russell, 1956). They may also have difficulty in obtaining meanings from pictures. They may be thought of as having an incomplete data bank.

Piaget has illustrated that the child's response to reality is largely determined by his perceptual processes. (Wohlwill, 1962). Generalization from one learning task to another is not possible until mastery at the earlier level is achieved. The process is described by Roach and Kephart (1966):

> "Two highly structured repositories of movement responses are developed: one resulting from patterned differentiation of specific elements out of a generalized mass; the other resulting from a patterned integration of specific elements into a structured whole (p. 6)."

Perceptual knowledge is built upon this motor knowledge. The resultant skill is the ability to perform a perceptual-motor matching of data. A breakdown in the matching process takes place when these two modes do not fuse, and the child lives, in a manner of speaking, in two worlds because the data he receives from one mode is not identical to that received from the other. (Roach & Kephart, 1966).

Disabilities tend to compound themselves. When children are asked to build on undeveloped skills, on experiences which they never had, and concepts they have yet to establish, failure is almost always assured. (Harding & Ridgeway, 1967). It should be noted, parenthetically, that there may be children with perceptual-motor dysfunction who are able to make compensatory adaptations and, as a result, do not develop either learning disabilities or secondary emotional disturbances. (Capobianco, 1964; Lowder, 1956; Potter, 1949; Strauss & Kephart, 1955).

Problems of symbolization are symptomatic of the inability to represent experience.

> "Observed most commonly are deficits in ability to learn to estimate and recall time, size, distance, volume, shape, height, speed and other...aspects of experience. (Johnson & Myklebust, 1967, p. 35)."

Spatial and temporal judgement may be impaired. Tasks requiring copying have been developed which reveal inefficiencies in non-verbal symbolization. (Gesell & Armatruda, 1947).

Symbolization deficiencies in language are sometimes demonstrated by echolalia and word-calling. Words can be repeated, or even translated from visual to spoken form, without the child being able to attach any meaning to the sound. Sometimes, the problem is one of selection, particularly in the auditory reception of language. The child may react non-differentially to all sounds in his environment, unable to discriminate between the important and the inconsequential or irrelevant.

Because of the spatial and temporal aspects of the involvement, the child often has trouble carrying out directions that are presented in a series, yet he could perform each task if it is presented singly. (Kephart, 1960).

Many educational objectives are defined by the concepts which the child must acquire. Concept formation is a function of the interaction of the previously described psycho-motor skills which permit the child to make abstractions. If the common denominator of a group of experiences is not recognized by the child, he is then incapable of the generalization, integration, and categorization necessary to concept formation.

It is believed that there may be an undetermined number of children in our schools who are disabled by perceptual-motor deficits. Some of these children may have been identified by school personnel as non-learners, slow learners, behavior problems, emotionally disturbed, or any of the other classifications described earlier.

Studies of the incidence of perceptual-motor deficits among children who were diagnosed as "emotionally disturbed" (Rubin, Simson & Betwee, 1966) substantiate the need for further investigation. In reviewing the reasons for referral of children for placement in the adjustment class program of the Mental Health Services in the Pittsburgh Public Schools, during the school year 1966-1967, it was found that 31 percent of them were suspected of perceptual-motor dysfunction or minimal brain damage. (Richman, 1967).

Children who are maladjusted in school may be found to be classifiable in at least three sub-sets:

1. Those with primary emotional disturbances resulting from disturbed interpersonal relationships or adverse psycho-social influences
2. Those with secondary emotional disturbances stemming from learning disabilities caused by perceptual-motor dysfunction
3. Those with primary emotional disturbances, accompanied by perceptual-motor deficits.

III. Method of Research

A. Statement of the Problem

The research addressed itself to a study of three populations in the Pittsburgh Public Schools, one drawn from regular elementary school classes, children from special classes for educable mental retardates, and children from the adjustment class program for emotionally disturbed and socially maladjusted children.

The questions to be answered are:

1. Can a test battery or survey be developed and refined which is sufficiently valid, reliable and discriminating, so that it may be used to identify children with perceptual-motor dysfunction?
2. What is the rate of incidence of perceptual-motor dysfunction in each of these populations, as measured by this instrument?
3. What are the curricular and programmatic implications of the findings?
4. Can an adapted form of this battery or survey be developed, which can be used by a classroom teacher for gross diagnosis of children with perceptual-

motor dysfunction, without losing validity, reliability and discriminability?

B. Population

At the time of this study, there were 75 children assigned to the adjustment class program, 60 boys and 15 girls, a ratio of about four to one, in seven elementary schools and in Pressley House, a private residential psychiatric facility for children. Of the seven elementary schools, all but one are located in "poverty" areas, as defined by the Office of Economic Opportunity. The remaining school is in a predominantly middle-class district. The children range in age from six to twelve years. Although a potentially normal intelligence is a criterion for admission to the adjustment class program, IQ scores range from 58 to 113.

With the exception of Pressley House, the children in the adjustment class program were assigned there by the decision of a school conference group which consists of a Mental Health Services psychiatrist and social worker, the principal, school social worker, the adjustment class teacher, and other relevant school and social agency personnel. The process of evaluation and assignment is described in greater detail in the Evaluation Report of the Mental Health Services, published by the Pittsburgh Board of Public Education. (Richman, 1967).

Initially, these children were referred to the Mental Health Services program because of school adjustment problems and/or learning difficulties. Their assignment to the adjustment class program was made to help the school to contain them, and to provide them with special support and remedial education which would enable them to return to regular classes as soon as possible. (Richman, Stickney & Wilson, 1967).

Attendance in the adjustment class varied with the needs of the child and the school, and ranged from five periods per week to temporary full-time participation. The part-time adjustment class students were maintained in regular classes for the balance of their school day.

Fifty children in regular classes and fifty educable mentally retarded children in Special Education classes, from five of the elementary schools which contained the adjustment class program were selected, as a stratified random sample, to be screened for perceptual-motor dysfunction. They met the following selection criteria:

1. Age matched closely with the adjustment class children
2. IQ score not higher than 113
3. Ratio of approximately four boys to one girl
4. No notation on the permanent school record of any relevant disability or handicap.

Twenty-five of the adjustment class children were randomly selected from the total sample, constituting a hold-out sample, and an additional twenty-five educable mental retardates and twenty-five children from regular classes were screened, in an elementary school which does not contain an adjustment class program. This was done for the purpose of cross-validation, which will be discussed later.

C. Method

In the Fall of 1967, the Mental Health Services acquired the services of a consultant[1], an optometrist with considerable experience in the area of perceptual-motor development in children. He had developed a battery of tests, which he had used for some time in his clinical practice and in other school consultation work, for the identification of children with perceptual-motor dysfunction. This battery consisted of some standardized subtests and some involving clinical judgement.

Using this as a starting point, the investigator, in collaboration with the consultant, arranged the subtests in sequence, re-defined and clarified the criteria for each, developed a scoring system, and titled the instrument the Rosner Perceptual Survey (RPS) to be described later.

A second instrument was devised, the Rosner-Richman Perceptual Survey (RRPS), based on the first, which included all the subtests except the optometric items and those which required special equipment (i.e. the split-form board and the tactual-visual subtest). It was hoped that the RRPS, if validated, could be administered by a classroom teacher, or other school personnel, as a gross screening device.

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[1] Jerome Rosner, O. D.

Children were tested individually by the consultant, in an available room in each school, two mornings per week. During the testing of the children from regular classes and those from classes for the educable mentally retarded, the investigator was also present, as an observer, and rated the children at the same time, using the RRPS.

D. Instruments

The Rosner Perceptual Survey (RPS) consists of 17 subtests and takes about 30 minutes to administer. Identifying information includes the child's name, school, grade, birthdate and IQ score.

1. General Status: to determine the child's general orientation (i.e. knowing his age, which hand he uses, his birthday, etc.)
2. Word Repetition: to test the child's ability to hear and repeat several multi-syllabic words spoken by the tester. (Rosner, 1966).
3. Near Visual Acuity: to determine the ability of the eye to discriminate standard size print at a standardized distance. A Snellen fraction is used to express the acuity. (Optometric).
4. Stereopsis: to determine the ability to demonstrate depth perception, using the Titmus Stereo Test. This is a subjective measure. (Optometric).
5. Auditory Organization: to determine the ability to analyze and synthesize auditory information. (Rosner, 1966).

6. Developmental Drawing: to determine the child's level of form perception, his spatial judgement in response to visual stimuli, and to uncover inefficiencies in non-verbal symbolization. (Gesell & Armatruda, 1941).

7. Cover: an objective test to determine the stability of binocularity at 16 inches and at optical infinity. (Optometric).

8. Near Point of Convergence: to determine the ability for both eyes to converge. The near point of convergence is that point at which both eyes can no longer maintain binocular fixation. (Optometric).

9. Ocular Pursuits: to determine the ability of one or both eyes to establish and maintain contact, and to track or follow a moving target in space. (Optometric).

10. Retinoscopy: an objective measure for determining the refractive status of the eyes. (Optometric).
    a. Static: conducted while the eye is fixated at optical infinity.
    b. Bell: near-point test using a non-specific target.
    c. Book: near-point test to evaluate integrative functioning, while reading.

11. Motor Skills: to determine the developmental level of gross motor skills, involving coordination, unilaterality, bi-laterality and control. (Roach & Kephart, 1966; Orton, 1937).

12. Body Image: to determine the child's level of spatial development, based on his sense of space localization. (Piaget, 1952; Piaget & Inhelder, 1956; Roach & Kephart, 1966).

13. Rhythmic Hop and Rhythmic Tap: to determine the level of ability to make bi-lateral shifts, to establish and maintain rhythmic motor patterns, and gross muscular control. (Roach & Kephart, 1966).

14. Split-Form Board: to determine the ability to synthesize visual information. (Rosner, 1966, Getman, 1959, based on Seguin, 1907).

15. Auditory-Visual: tests inter-sensory integrative functions and inter-modality relationships. (Birch & Belmont, 1965).

16. Tactual-Visual: tests the ability to integrate visual and tactile, kinesthetic information, using a form board. (Rosner, 1966).

17. Rutgers Drawing Test: tests the non-verbal skills of motor coordination, figure-ground relationship, visual perception and analysis of design. (Starr, 1961).

The Rosner-Richman Perceptual Survey (RRPS) is made up of all the RPS items except 3, 4, 7, 8, 9, 10, 14, and 16, and takes about fifteen minutes to administer. Each of the items in both instruments is rated on a three-point scale; 3 represents an adequate performance, 2 represents partial performance, or performance with difficulty, and 1 represents an inadequate performance. Because the tasks are developmental, scoring is done relative to the age of the child. The RPS has a possible total score of 90, a partial score of 57, corresponding to the total score of the RRPS, and an optometric sub-score of 33, representing the remaining items.

Behavior Rating Scale

In order to secure an index of external validity for the RPS and the RRPS, a summated rating scale was constructed[1], based on the behavioral correlates of learning disabilities described in the literature. (Capobianco, 1964). The scale was distributed to the teachers of the fifty children from regular classes who had been tested with the RPS and the RRPS. The children from regular classes were chosen for this part of the investigation because the incidence rate of perceptual-motor dysfunction was expected to be lower than that of the other two groups. This instrument, therefore, would have to demonstrate a considerable ability to discriminate.

A five-point scale was used: 1- always; 2- frequently; 3- occasionally; 4- rarely; 5- never. The direction of the items was varied to control for response set. Before statistical procedures were applied to the scores, the items were restored to a

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[1] This work was done by Marion Karl, Graduate Assistant in Educational Research, University of Pittsburgh, under the direction and supervision of the University, Dr. Russell Scott, Assistant Director, Research Office, Pittsburgh Public Schools, and Vivien Richman, Research Associate, Mental Health Services, Pittsburgh Public Schools.

12. *Body Image*: to determine the child's level of spatial development, based on his sense of space localization. (Piaget, 1952; Piaget & Inhelder, 1956; Roach & Kephart, 1966).
13. *Rhythmic Hop and Rhythmic Tap*: to determine the level of ability to make bi-lateral shifts, to establish and maintain rhythmic motor patterns, and gross muscular control. (Roach & Kephart, 1966).
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A five-point scale was used: 1- always; 2- frequently; 3- occasionally; 4- rarely; 5- never. The direction of the items was varied to control for response set. Before statistical procedures were applied to the scores, the items were restored to a one-directional scale and degrees reduced to three. One indicated frequent problem behavior; two indicated occasional problem behavior; and three indicated normal behavior. The scale is composed of 30 items and the maximum total score is 90.

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[1] This work was done by Marion Karl, Graduate Assistant in Educational Research, University of Pittsburgh, under the direction and supervision of the University, Dr. Russell Scott, Assistant Director, Research Office, Pittsburgh Public Schools, and Vivien Richman, Research Associate, Mental Health Services, Pittsburgh Public Schools.

IV. Findings

The means and standard deviations of the Rosner Perceptual Survey (RPS) and the Rosner-Richman Perceptual Survey (RRPS) were computed for the children from regular classes, the emotionally disturbed, and the educable mentally retarded children. These are reported in Table 1.

No significant difference was found among the schools. A break-down of means and standard deviations by schools will be found in the Appendix. No significant difference was found between the emotionally disturbed and the mentally retarded children's scores. There was, however, a significant difference between the regular class scores and the other two groups at the .005 level.

Table 1.

Means and Standard Deviations on RPS and RRPS of Children from Regular Classes, Emotionally Disturbed and Educable Mentally Retarded Children

	RPS			RRPS	
Group	Number	Mean	S.D.	Mean	S.D.
Regular	50	76.88	5.66	48.94	4.32
Emotionally Disturbed	75	65.55	9.34	40.50	6.26
Mentally Retarded	50	65.20	6.19	39.45	3.67
	N=175				

The analyses of variance are reported in Tables 2, 3 and 4. for the RPS, the RRPS and the RPS by schools.

Table 2.

Analysis of Variance: RPS

Source of Variance	df	MS	F	p
Between groups	2	2351.9	40.85	<.005
Within groups	172	57.6		

Table 3.

Analysis of Variance: RRPS

Source of Variance	df	MS	F	p
Between groups	2	595.7	19.92	<.005
Within groups	78	27.4		

Table 4.

Analysis of Variance: RPS
by School

School	Source of Variance	df	MS	F	p
Arsenal	Between groups	2	399.93	7.98	<.005
	Within groups	28	50.13		
Holmes	Between groups	2	415.79	10.48	<.005
	Within groups	26	39.67		
Weil	Between groups	2	405.25	8.76	<.005
	Within groups	33	46.25		
Conroy	Between groups	2	732.76	14.85	<.005
	Within groups	30	49.35		
Friendship	Between groups	1	585.23	9.95	<.025
	Within groups	16			

The intercorrelation matrix shown in Table 5 indicates that those items which are sub-tests within a single test item have the highest correlation with each other, as could have been expected (e.g., 18 and 19 are sub-scores of the Rutgers Drawing Test.)

Of the 30 items, all but one (item 11) correlated with the total score at the .005 level. Only two items, 11 and 17, have a correlation of less than .30 with the total score.

The intercorrelation matrix yielded three major groups of items which were further subdivided into sub-groups:

Table 5.

Intercorrelations of RPS Items
(significant at .005 level)*

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Gen.status	1																														
Word repet.	2	34																													
Aud. org.	3																														
Dev. drawing	4	25	22																												
	5	35			42																										
	6	39	23		45	66																									
Motor skills	7																														
	8							53																							
	9							42	67																						
	10		19					44	49	49																					
	11								21		19																				
	12						20	35	27	19	24	47																			
Body image	13	44	[illegible]	24			25	20																							
Rhythmic	14	27	34	35	25	20	27		21		30		19	37																	
hop-tap	15	33	35	44	26	28	42						21	37	64																
Audit.-vis.	16	36	20	32	19	20	33							32	36	42															
Pencil grip	17							24		19																					
Visual anal.	18	30	19	21	43	58	53								32	36	29														
	19	42	31	26	40	56	61							31	32	46	43		81												
Near VA	20	20				22	21												22	25											
Stereopsis	21					33	28							19			20		20	19	27										
Cover-Far	22						22	21		28	21		21									39									
Near	23									24	22											31	70								
N. P. C.	24									22												33	63	57							
Pursuits	25							32	25	23	25			26					20	24		36	41	43	46						
Retinoscopy	26				21		20													22	44	26	33	28	26	23					
	27				21		20														35	29	42	32	36	34	78				
	28																				36										
Split Form	29	33				28	36									21	21		34	34											
Tactual-vis.	30	21				23								31						20	19									19	
Total Score	31	51	39	22	49	58	64	34	36	37	37		30	51	47	57	45	23	59	67	41	47	50	44	41	51	45	45	41	36	31

* Decimal points omitted for clarity.

I. A. Visual analysis, form perception and motor coordination
  B. Auditory organization, inter-sensory integrative functions
  C. Spatial development and synthesis of visual information

II. Gross motor skills

III. A. Visual acuity and refractive status
  B. Depth perception, binocularity, convergence, and ocular pursuits.

Pearson Product-Moment correlations between the RPS and the RRPS were computed, by group, and are reported in Table 6.

Table 6.
Correlation of RPS with RRPS

Group	r	p
Regular	.76	.005
Emotionally disturbed	.83	.005
Mentally retarded	.75	.005

Inter-rater reliability was demonstrated by a Pearson Product-Moment correlation of .78 for the scores of the mentally retarded children and .91 for the scores of the children from regular classes.

A measure of external validity was obtained from a Pearson Product-Moment correlation of .52 between the Behavior Rating Scale (see page 20) and the RPS, significant at the .001 level.

An inspection of the distribution of scores revealed the cut-off scores for each instrument. Applying these points to the data, the incidence rates described in Table 7 were found:

Table 7.

Incidence of Perceptual-Motor Dysfunction

Group	RPS	RRPS
Regular classes	.13	.13
Emotionally Disturbed	.70	.68
Mentally Retarded	.90	.97

A cross-validation sample of 50 children from regular classes and classes for the educable mentally retarded was tested at Larimer School. It is interesting to note that the incidence rate for the mentally retarded sample was 89 percent, which approximates the other findings. Among the children in regular classes, however, the incidence rate was 30 percent, which is considerably higher than the 13 percent found in the study.

Seventeen percent of the children from regular classes demonstrated optometric deficits, as compared with 60 percent of the emotionally disturbed children and 51 percent of the mentally retarded.

Further analyses of the data are being planned for the Fall, including a factor analysis and a discriminate analysis, which will yield further information. A supplementary report will be issued when the analyses are completed.

V. Discussion and Conclusion

Based on the preceding analysis, it is believed that the two instruments, the Rosner Perceptual Survey (RPS) and the Rosner-Richman Perceptual Survey (RRPS) can be used with considerable confidence to identify children with perceptual-motor dysfunction.

While the RPS requires the skills of an optometrist to administer it, it yields a more descriptive and detailed clinical profile. The RRPS can be administered by a classroom teacher or by a para-professional. Inter-instrument and inter-rater reliability were established, as well as a measure of external validity.

The instruments in their present form can discriminate between children with adequate perceptual-motor development and those with disabilities. The RPS not only investigates the performance of specific, individual perceptual-motor skills, but also tests the performance of integrated multi-sensory skills.

The high rate of incidence of perceptual-motor dysfunction among the emotionally disturbed and mentally retarded children raises several interesting questions about the relationship between these conditions. Does the existence of emotional disturbance or mental retardation in a child contribute to distorted perceptual-motor functioning? Or does the existence of perceptual-motor dysfunction produce secondary symptoms of emotional disturbance or mental retardation?

If the latter is so, then the children in special classes for the disturbed and the retarded may have been classified and assigned to those programs on the basis of what may be secondary symptoms.

What is the reason for the high rate of incidence of perceptual-motor dysfunction among children from regular classes at Larimer School? Larimer School is located in a poverty area. The study also took place in poverty districts, but included a middle-class school and a residential school. Could this account for the difference?

Is the incidence rate higher in very low socio-economic areas than in middle-class areas? Does the poverty life-style, which may include early sensory deprivation, or undifferentiated sensory over-stimulation, absence of manipulatory materials, etc. have an effect on the perceptual-motor development of children?

Does poor nutrition, poor pre- and post-natal care affect the child's perceptual-motor development?

Perhaps the most important questions to be raised are concerned with treatment. Is perceptual-motor dysfunction, as defined in this study, irreversible? Can a program be designed to habilitate or rehabilitate the children who are disabled? How early in the child's school life can perceptual-motor dysfunction be identified? How will a rehabilitation program affect school achievement, IQ, and school adjustment? What changes must be made in dealing with children who are not learning in school? What curricular changes should be made in classes for the emotionally disturbed and the mentally retarded?

Through the continued generosity of the Maurice Falk Medical Fund, and with the interest of the Pittsburgh Public Schools, these questions will be the focus of the research to be conducted by the Division of Mental Health Services during the 1968-1969 school year.

REFERENCES

Barsch, R. H. Perspectives on learning disabilities: the vectors of a new convergence. *Journal of Learning Disabilities*, 1968, 1, 7-20.

Bender, L. *Psychopathology of children with organic brain disorders*. Springfield: Charles C. Thomas, 1956.

Birch, H. G. & Belmont, L. Auditory-visual integration, intelligence and reading ability in school children. *Perceptual and Motor Skills*, 1965, 20, 295-305.

Braun, Jean, Rubin, E.Z., Llorens, Lela & Beck, Gayle. Cognitive motor deficits--definition and intervention. Paper presented at Convocation on Learning Disabilities, Pittsburgh, Pa. Feb. 1967.

Capobianco, R.F. Diagnostic methods used with learning disability cases. *Exceptional Children*, 1964, 31, 187-193.

Coleman, H. Visual perception and reading dysfunction. *Journal of Learning Disabilities*, 1968, 1, 117-123.

Flavell, J. H. *The developmental psychology of Jean Piaget*. Princeton, N.J.: Van Nostrand, 1963.

Full, H. *Controversy in American education*. New York: MacMillan, 1967.

Gesell, A. *The mental growth of the pre-school child*. New York: MacMillan, 1925.

Gesell, A. & Armatruda, C.S. *Developmental diagnosis: normal and abnormal child development*. New York: Paul B. Hoeber, 1941.

Getman, G. N. *Diagnostic criteria for the optometric care of children's vision*. Optometric Extension Program, Duncan, Okla., 1959.

Harding, N. G. & Ridgeway, R. W. Early identification of children with learning disabilities. *Exceptional Children*, 1967, 33, 387-394.

Havighurst, R. J. The educationally difficult student. In Full, H. *Controversy in American education*. New York: MacMillan, 1967, 216-230.

Rosner, J. *Visual Perceptual Survey*. An evaluation designed for the Oakmont Public School District, Oakmont, Pa. ESEA, Title I, 1966, Mimeographed report.

Rubin, E. Z., Simson, C. & Betwee, M. *Emotionally handicapped children and the elementary school*. Detroit: Wayne State Univ. Press, 1966.

Russell, D. *Children's thinking.* Chicago: Ginn, 1956.

Schafer, W. E. Deviance in the public school. In Thomas, E. J. (Ed.) *Behavioral science for social workers,* New York: The Free Press, 1967.

Seguin, E. *Idiocy: and its treatment by the physiological method*. Albany: Brandow Printing Co., 1866. Reprinted New York: Teachers College, Columbia Univ. 1907.

Starr, A. S. *The Rutgers Drawing Test, an initial report*. New Brunswick, N. J. Author, 1961.

Strauss, A. A. & Kephart, N. C. *Psychopathology and education of the* brain-injured child. Vol. II, New York: Grune & Stratton, 1955.

Thomas, E. J. (Ed.) *Behavioral science for social workers*. New York: The Free Press, 1967.

Vinter, R. D. & Sarri, Rosemary C. Malperformance in the public school: a group work approach. In Thomas, E. J. (Ed.) *Behavioral science for social workers.* New York: The Free Press, 1967.

Weener, P., Barritt, L.S. & Semmel, M. I. A critical evaluation of the Illinois Test of Psycholinguistic Abilities. *Exceptional Children*, 1967, 33, 373-380.

Wohlwill, J. F. From perception to inference: a dimension of cognitive development. In Kessen, W. & Kullman, C. (Eds.) *Thought in the young child*. Monogr. Soc. Res. Child Development, 1962, 27, 87-107.

Wunderlich, R. C. Learning disorders - a developmental approach. *Journal of Learning Disabilities*, 1968, 1, 128-133.

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Itard, J. M. The wild boy of Aveyron. New York: Appleton-Century-Crofts, 1932. (original publication, 1799).

Jansky, J. A severe case of dyslexia. The Reading Teacher, 1961,15, 110-113.

Johnson, D. J. & Myklebust, H. R. Learning disabilities. New York: Grune & Stratton, 1967.

Kephart, N. C. The slow learner in the classroom. Columbus, Ohio: Charles E. Merrill, 1960.

Kessler, Jane W. Psychopathology of childhood. Englewood Cliffs, N.J.: Prentice-Hall, 1966, 200-226.

Lowder, R. C. Perceptual ability and school achievement: an expository study. Cited in Roach, E. G. & Kephart, N. C. The Purdue Perceptual-Motor Survey, Columbus, Ohio: Charles E. Merrill, 1966.

Montessori, Maria. The secret of childhood. New York: F. A. Stokes, 1939.

Myklebust, H. R. & Johnson, D. J. Dyslexia in children. Exceptional Children, 1962, 29, 14-25.

Orton, S. Reading, writing and speech problems in children. New York: W. W. Norton, 1937.

Ozer, M. N. The neurological evaluation of school-age children. Journal of Learning Disabilities, 1968, 1, 87-89.

Piaget, J. Psychology of intelligence. New York: Harcourt, Brace, 1950.

Piaget, J. The origins of intelligence in children. New York: International Press, 1952.

Piaget, J. & Inhelder, B. The child's conception of space. London: Rutledge & Kegan Paul, 1956.

Potter, M. C. Perception of symbol orientation and early reading success. Teachers College, Columbia Univ. Contributions to Education, No. 939, 1949.

Richman, Vivien C. Evaluation report, Mental Health Services. Pittsburgh Public Schools, 1967.

Richman, Vivien C., Stickney, S. B. & Wilson, G. J. Mental Health Services in the Pittsburgh Public Schools. Journal of the Internatl. Assn. of Pupil Personnel Workers, 1967, 2, 91-95.

Roach, E. G. & Kephart, N. C. The Purdue Perceptual-Motor Survey. Columbus, Ohio: Charles E. Merrill, 1966.

Rosner, J. *Visual Perceptual Survey*. An evaluation designed for the Oakmont Public School District, Oakmont, Pa. ESEA, Title I, 1966, Mimeographed report.

Rubin, E. Z., Simson, C. & Betwee, M. *Emotionally handicapped children and the elementary school*. Detroit: Wayne State Univ. Press, 1966.

Russell, D. *Children's thinking.* Chicago: Ginn, 1956.

Schafer, W. E. Deviance in the public school. In Thomas, E. J. (Ed.) *Behavioral science for social workers,* New York: The Free Press, 1967.

Seguin, E. *Idiocy*: *and its treatment by the physiological method*. Albany: Brandow Printing Co., 1866. Reprinted New York: Teachers College, Columbia Univ. 1907.

Starr, A. S. *The Rutgers Drawing Test, an initial report*. New Brunswick, N. J. Author, 1961.

Strauss, A. A. & Kephart, N. C. *Psychopathology and education of the* brain-injured child. Vol. II, New York: Grune & Stratton, 1955.

Thomas, E. J. (Ed.) *Behavioral science for social workers*. New York: The Free Press, 1967.

Vinter, R. D. & Sarri, Rosemary C. Malperformance in the public school: a group work approach. In Thomas, E. J. (Ed.) *Behavioral science for social workers.* New York: The Free Press, 1967.

Weener, P., Barritt, L.S. & Semmel, M. I. A critical evaluation of the Illinois Test of Psycholinguistic Abilities. *Exceptional Children*, 1967, 33, 373-380.

Wohlwill, J. F. From perception to inference: a dimension of cognitive development. In Kessen, W. & Kullman, C. (Eds.) *Thought in the young child*. Monogr. Soc. Res. Child Development, 1962, 27, 87-107.

Wunderlich, R. C. Learning disorders - a developmental approach. *Journal of Learning Disabilities*, 1968, 1, 128-133.

APPENDIX

Table 1.

Means and Standard Deviations of Children from Regular Classes on RPS and RRPS

		RPS		RRPS	
School	Number	Mean	S. D.	Mean	S. D.
Arsenal	10	78.60	6.41	50.90	4.16
Conroy	10	77.90	5.22	48.20	5.19
Holmes	10	77.30	5.02	48.80	2.86
Weil	10	75.50	5.77	47.80	4.81
Friendship	10	75.10	4.57	49.00	4.60
Total N = 50	M = 76.88	S.D. = 5.66			

Table 2.

Means and Standard Deviations of Educable Retarded Children on RPS and RRPS

		RPS		RRPS	
School	Number	Mean	S. D.	Mean	S. D.
Arsenal	12	66.50	5.58	40.58	3.62
Conroy	17	64.41	5.41	38.41	4.04
Holmes	9	66.89	5.99	41.00	4.24
Weil	12	63.75	7.08	37.83	2.79
Total N = 50	M 2 65.20	S.D. = 6.19			

Table 3.

Means and Standard Deviations of Adjustment Class Children on RPS and RRPS

		RPS		RRPS	
School	Number	Mean	S. D.	Mean	S. D.
Arsenal	9	72.44	8.30	45.89	6.51
Conroy	6	61.33	10.87	39.50	7.59
Holmes	10	65.40	6.76	41.50	5.12
Weil	14	66.50	6.50	41.86	4.67
Friendship	8	63.63	9.56	38.12	6.58
Pressley House	15	65.47	8.20	39.93	6.16
Murray	6	64.67	8.48	39.83	4.26
Colfax	7	61.71	13.21	37.43	9.26
Total N = 75 M = 65.55 S.D. = 9.34					

Behavior Rating Scale

Name________________________Age___Grade_____School___________________

Rated By_________________________Subject__________Home Room_________

Directions: Please rate this student on the following items. Place a number in the blank to the left of the item which describes the degree to which the item is true of the student's classroom behavior.
1.- ALWAYS 2.-FREQUENTLY 3.- OCCASIONALLY 4.- RARELY 5.- NEVER

___ Hyperactive
___ Understands gestures or words of others
___ Easily distracted
___ Short attention span
___ Follows directions well
___ Poor auditory memory
___ Poor visual memory
___ Achieves your level of expectation for him/her
___ Awkward or clumsy
___ Ambidextrous
___ Illegible handwriting
___ Uses only one hand at a time with no assistance from the other
___ Shows transfer of learning from one situation to another
___ Poor organization of work space and work time
___ Pays too much attention to detail, misses the total picture
___ Pays too little attention to detail, misses the total picture
___ Has trouble working with numbers
___ Is able to interpret or manipulate symbols, such as maps, charts, graphs
___ Shows confusion about right, left, or other directional orientation
___ Reverses letters or words in reading
___ Reverses letters or words in writing
___ Unorthodox sentence structure
___ Halting or stumbling oral delivery
___ Clear, distinct speech
___ Stutters
___ Scrambled spelling
___ Long, rambling story telling
___ Distortion in repeating sounds
___ Adequate reading comprehension
___ Poor oral reading fluency

AN ANALYSIS AND EVALUATION OF PSYCHIATRIC CONSULTATION

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April 1968

PSYCHIATRIC CONSULTATION TO PROJECT UPWARD BOUND

During the school year 1966-1967, and continuing to the present time, Dr. Stonewall B. Stickney, Psychiatrist and Director of the Division of Mental Health Services in the Pittsburgh Public Schools, was invited to serve as the psychiatric consultant to Project Upward Bound. Because the style of consultation with the school personnel involved in Project Upward Bound is essentially the same as that used regularly in the Mental Health Services program in the Pittsburgh Public Schools, it was believed that an examination and evaluation of this activity would have relevance to school consultation practice in general. Principles underlying school consultation were identified and defined in the Evaluation Report (Richman, 1966, pp. 51-53), published by the Pittsburgh Public Schools.

Project Upward Bound is a program designed to provide special help for the able, disadvantaged student who is not achieving up to his potential. Participants include students from various Pittsburgh high schools, and the staff consists of teachers, social workers and counselors. Psychiatric consultation occurred on a regularly scheduled bi-weekly basis and centered around specific students who were the cause of staff concern.

Statement of the Problem

The purposes of this report were to describe and analyze the conference process, and, through a written questionnaire, to evaluate the effectiveness of the psychiatric consultation, as perceived by the Project Upward Bound staff.

Method

The investigator, who has observed many school consultation conferences over the past two years, as Research Associate for the Division of Mental Health Services, attended a Project Upward Bound conference in February 1968, in order to determine whether the underlying principles of consultation practice had been changed or clarified.

An open-ended, evaluative questionnaire was developed and mailed to the Project Upward Bound staff members who had been the most frequent participants in the consultation conferences.

Findings

A. The Consultation Conference

The conference was essentially a democratic discussion, largely self-directed and informal. It moved along quite smoothly without a formal, overt "discussion leader". Attention was focussed on the child under discussion, rarely, if ever, straying from the business at hand.

Notes or records were utilized infrequently, usually to corroborate information which was presented orally. Participants apparently relied, with confidence, on their impressions, observations, and their abilities to remember and describe behavior and interactions. The tone of the conference was purposeful, but warm and relaxed. New participants were welcomed and included in the discussion. Contributors were not competitive with each other, but listened attentively and spoke respectfully to each other. Comments were not directed to any one person but were offered to the entire group.

Obvious and overt leadership occurred in the early part of the meeting, when the psychiatric consultant asked the teacher a series of brief questions, intended to elicit a behavioral description of the student under discussion.

1. Descriptive Information:

What is outstanding about this boy?
What is different about him?
What does he look like?
What are his parents, brothers and sisters like?
What does he think is wrong?

This was followed by tentative and speculative explanations of the descriptive material by the psychiatric consultant, who encouraged the other participants to contribute to the discussion.

2. Tentative, Speculative Explanation:

It sounds as if he is afraid of losing everything...
He doesn't seem to fit with his family...
He doesn't get much from people, does he?...

As more information was presented about the boy's in-school and out-of-school behavior, his conversations with staff, and his family situation, the psychiatric consultant moved the group toward agreement about the interpretation and diagnosis of the problem.

3. Interpretation and Diagnosis:

What do you think will happen if we don't do anything?

He says he thinks he is paranoid...

I think he's paranoid too...

I think I (psychiatric consultant) ought to see him.

From this, the group proceeded to develop a plan of action for the boy, and to create a strategy to implement it. Many alternatives were presented, discussed, discarded or refined, until a plan was agreed upon and the responsibility was fixed for carrying it out.

4. Plan of Action, Strategy, Implementation:

What about working through the parents?

How do we handle his self-diagnosis?

How can we suggest that he talk with the doctor?

He can continue to see the social worker...

It can be seen from the outline presented above that the consultation conference continued to be primarily teacher-centered and behavior-oriented. A climate was created by the psychiatric consultant which encouraged all the participants to make their contributions to the conference. This was accomplished by the psychiatric consultant's occasional use of direct questions which elicited information and stimulated relevant recollections from others. Information or speculation was received with great interest and respect by the psychiatric consultant, and this general attitude also contributed to the climate of the conference. The use of wit and humor added warmth and released tensions. People will generally tend to participate freely in a group if they have been led to believe that their contributions will be welcomed and considered valuable. The psychiatric consultant, further, did not assume the role of the omnipotent "expert", which encouraged the participants to share actively in the diagnostic and planning aspects of the conference.

The sequence of the various segments of the conference process were generally similar to the regular Mental Health Services consultation conferences in the Pittsburgh Public Schools, namely: 1) eliciting descriptive behavioral information, 2) tentative, speculative explanations, 3) interpretation of data and diagnosis, and 4) planning for action, strategy and implementation.

Because the conferences took place on a regularly-scheduled basis, it was implicit that the psychiatric consultant and the group would have continuing opportunities to review and re-evaluate their previous planning so that appropriate alterations could be made, as needed.

B. The Evaluative Questionnaire

Of the 17 questionnaires which were mailed out, 13 or 76 percent were returned. The respondents had attended from two to almost all of the consultation conferences. All but one person found these conferences to be significantly different from any other case conference they had attended. Two had no previous comparable experience.

The responses to the other items in the questionnaire are reported and summarized below.

Question: In what ways have these conferences been different?

> "Pattern was similar (to other conferences), but leadership and direction by Dr. Stickney was vastly superior to any of them."
>
> "Specific problems were dealt with and specific recommendations were made..."
>
> "The staff benefited greatly. I feel as though the sessions were designed to have the staff evaluate themselves."
>
> "More learning for participants. Freer. Focussed on what can and will be done. Opportunity for everyone to be involved honestly, whether in agreement or disagreement."
>
> "...the conferences have been intelligent, sensible and practical."
>
> "This is the first time a psychiatrist rather than a clinical psychologist or social worker's judgement has been available directly."
>
> "Approach, scope, depth of insight, realistic plan for solution with involvement of client."
>
> "The consultant relies primarily upon information heard for the first time. He is able to detect new themes never crystalized by any one participant closely associated with the student. A genuinely fresh examination is possible, permitting treatment which will present a really new environmental response to a persistent problem."

Question: Has the psychiatric consultation been useful to you in your work?

"I have retired and have had no opportunity to use the findings. My observations of staff members and others at meetings and in follow-up activities showed their growth and progress in their thinking processes and ability to find new ways to solve individual and family problems."

"In dealing with high school students living on a college campus, and in interpreting and understanding behavior."

"It has given me greater insight into the problems of the kinds of young people in the Project."

"I now try to understand the reasons why students behave as they do, and as a result, I have less of a tendency to be punitive and more of a tendency to be helpful."

"Dr. S. has always been ready and available for suggestions when kids run into difficulty. He has facilitated hospitalization, seen parents, kids, steered me to understanding school personnel, etc."

"The conferences brought teachers together to try to discuss intelligently the problems of students. Even in a small group the size of Project Upward Bound, I don't think that much discussion would have taken place without the conferences, and I know it wouldn't have been as sensible and practical."

"I can endure unusual behavior and respond with more tranquility when I understand the cause."

"Information has been valuable in working with others having similar problems."

"Has made me more cognizant of the many cognitive reasons which are always present in being responsible for a child's inert (sic) or overt difficulties."

"Has created deeper sensitivity in me..."

Question: Can you think of any specific learning which you acquired as a direct result of your participation in meetings with the psychiatric consultant?

"Recognition of contributions that persons of different backgrounds can make toward finding assistance and possible solution of problems that are very complicated."

"Many of the "problems" are really not problems, but how they are handled by educators can make the difference."

"Most of the specific learning was about the young people who were discussed."

"I have been able to apply much of the learnings about adolescent behavior obtained in college but never put to practice before Dr. Stickney tied the whole thing together."

"I have developed an increased appreciation for teachers' observations of students despite large classes and what I regard as inadequate teacher education and in-service training."

"These discussions freed the teachers to think of the students as individuals, rare even in small classes like PUB."

"Specific knowledge of case material gathered for purposes of those discussions...in every case, many instructors had not been made aware of information about students until the sessions with Dr. Stickney."

"One should gather as much information as possible, and from many sources."

"Very few if any of the students were incorrigible because there was always some experience which would place the student in the category of 'Now a person who does that can't be all bad.'"

"If you respond to a problem in the same manner as everyone else, you are probably contributing to strengthening that behavior rahher than changing it."

Question: Do you feel that your professional role has been affected by contact with the psychiatric consultant?

"Emotional problems of adolescents are difficult to interpret, understand and solve. Dr. Stickney, by his leadership, develops team thinking of the highest type, and as a result, brings out team planning of equally high quality... I would consider this psychiatric consultation one of the most valuable assets of the program. Most so-called trained personnel need this type of supplementary training. This applies to Directors, Teachers, Social Workers, Parents, and all others."

"I feel just a little different about problems youngsters face. My reactions to these problems are not the same."

"I need to be reminded from time to time that behavior has causes. These discussions help to remind me."

"I feel that I am more sensitive to people, their feelings, and reasons for acting as they do. It has allowed me to better control them through controlling their environment."

"I have been strengthened in my determination to cut through bureaucratic red tape to deal with unmet needs of the students and to reach out in unorthodox ways to deal with varied problems."

"Possibly, the conferences helped the teachers more than they did the students. (I wonder if teacher help wasn't their aim.) ...not only by explaining student motivations and problems to them but also by giving them assistance and encouragement in trying to help students. More awareness of and sympathy to student differences and difficulties have been the changes the conferences have made in me."

"My function as a teacher remains the same but I have a tendency to be more tolerant."

"I have welcomed the opportunity to contribute to the sessions and to receive information from other faculty members, to be considered and focused by the psychiatrist."

"My psychiatric orientation has been expanded. My recognition has increased as well as comprehension and sympathy."

"It has helped me to work with teachers and other counselors who wouldn't be affected by this particular consultant.

"I feel that my role has been clarified in directing people to sources of help."

Question: How would you describe the approach used in the conferences by the psychiatric consultant?

"When a psychiatrist such as Dr. Stickney is so skillful in making his technical knowledge so plain and applicable to most problems that educators, social workers, other professionals and parents can better understand the real needs of the child being discussed, much has been accomplished."

"Reality-oriented."

"Sticknerian!"

"Dr. Stickney always suggests or gets the staff to suggest why students behave as they do. We were always searching for reasons or causes."

"I don't think a psycho-analytic approach is emphasized, but I believe it is implied. I think the approach is primarily sociological with the emphasis on using existing strengths and health."

"I was impressed with the absence of jargon and theory in the discussions and the emphasis on practicality and common sense."

"The conferences are quite non-directive with emphasis on analyzing sources of problems rather than suggesting specific solutions. For the faculty, they offer much needed support in dealing with extreme behavior problems, both in overt and imminent cases."

"I'm not totally sure if it has been a psychoanalytic approach. Dr. Stickney would not get bogged down with trite jargon but would use this approach subtly and with salient results."

"The child's relationship to parents is very much emphasized... its transfer to the student-teacher relationship is often indicated. Reasons for behavior often have been attributed to the particular aspect of the parent-child relationship."

Question: Do you think that the psychiatric consultation should be continued at Project Upward Bound? Why?

"A continuous learning program must be carried on for all professional staff members. The psychiatric consultation procedure is in a class by itself in this respect. In addition, there is no other way whereby children or families with extremely serious problems may receive assistance except by private treatment."

"Yes. I feel the approach to PUB students is not through more academic work but rather dealing with the many problems these youngsters have."

"Yes. I have personally found it valuable."

"Yes. It is good for the students on whom we act, and good for the staff in analyzing why we feel or perceive as we do."

"Yes. The kids we deal with have many of the usual adolescent problems that must be dealt with and understood. In addition, the circumstances of their life and environment increase such problems. Professional help is essential."

"Yes."

"Yes. The sessions provide an excellent opportunity for concentrated attention to problems which are otherwise neglected for lack of time or knowledge."

"Yes. We are finding a variety of deep-seated emotional problems."

"Yes. They need it desperately!"

"Yes. Generally provides an important non-academic dimension to the relationship which teachers have to Project Upward Bound students. Is very easy for teachers to view students as one more vessel for them to fill with content. These consultations enlarge the relationship."

Question: What changes would you recommend in the utilization of a psychiatric consultant?

"None specifically. Follow-up meetings by smaller groups of those most closely concerned may be used to a greater extent. Examples...social worker with one or more instructors, social worker or instructor with parent, etc."

"Full-time employment in the program, both in winter and summer. A direct carry-over of consultation in schools with teachers and administrators."

"We could use more of his time."

"More students should be able to have a direct contact with a psychiatrist."

"No changes other than periodic meetings with staff groups, both large and small, to discuss the philosophy of the program and the staff's acceptance and/or rejection of it, as well as attitudes toward the student in this changing society."

"Use him more often."

"Increase in number of sessions to allow more students to be selected for consideration and review of cases which have been discussed."

"None."

"Sessions should certainly not be scheduled for Friday afternoons."

"More emphasis on treatment. More attention to the creation of a set of reinforcers which will modify the student's behavior regardless of the origin of his problems. During the school year, more home-school personnel should be invited, or urged to come."

Question: What has been the strongest aspect of the psychiatric consultation?

"Leadership by Dr. Stickney. His approach appears to be very easy and simple, but professional direction by a person with many skills in group therapy is an essential. In addition, Dr. Stickney possesses the "human touch" that gets at the seat of problems."

"Specific problems were dealt with."

"The effect upon the staff in changing attitudes and, possibly, behavior."

"Availability, follow-through, flexibility, and especially his respect and acceptance of all disciplines involved with students."

"Dr. Stickney."

"The interchange of reports from diverse sources and the intensive consideration of individual students. (The medium seems to be the message here!) The dynamics of the session have been valuable to teachers and project directors, especially in revealing the differences in teacher-student relationships. The sensitivity to the students' needs has certainly been increased."

"Involvement of total staff in gaining awareness, comprehension, planning."

"A greater understanding of the problems of the students and, in so many instances, the difficulties involved with many parents."

"The insight and personality of the consultant, plus the opportunity for a group of educators to come together to be concerned about the future of one of their students; but without a strong consultant to detect the central theme, the catharsis is not that valuable."

Question: What has been the weakest aspect?

"Follow-up processes. A program such as PUB must have a staff sufficiently large, competent and diversified to handle problems of a serious nature. High school students rarely would be in the program if they did not have problems more complicated and serious than the average."

"No carry-over into the high schools. No high school teachers present."

"After 10 sessions, the effect diminishes. A new approach might be established for staff members who have been to many, many sessions, perhaps more depth for them. However, at least 10 sessions are extremely valuable."

"Lack of time for regularly scheduled, frequent consultation."

"I sometimes chaffed at the time necessary to give the background of the student. Couldn't some of this material be dittoed and distributed before the meeting? I also thought there was too much 'Show and Tell' but I suppose it was inevitable."

"Immediate prescriptions not available."

"Not enough follow-up on the treatment; not enough reinforcement for those who are in a position to affect the treatment. They might make one fresh response, but if not immediately successful, it will not be repeated without support."

Question: Any other comments, suggestions, recommendations?

"It has been a great privilege to be invited regularly to these consultations and to have the privilege of participation."

"It seems to me that this component of the program can only be as significant and useful as the project director's acceptance and understanding of it. That element must always predominate."

"Why can't these conferences take place in the schools? I know. No time, no money and no men like Stickney."

"(Hopefully) This program would encourage greater availability of psychiatric services for all students in the schools, as well as those in Project Upward Bound."

> "Emphasis: consultation should be continued."
>
> "More emphasis on treatment, that treatment be more clearly stated, more follow-up on treatment efforts. But no one can doubt that a Stickney session necessarily deepens their sensitivity to student behaviors. I just think, however, that unless there is more specific treatment guidance, this sensitivity can simply deepen the frustration of a conscientious teacher."
>
> "Good Luck, Dr. Stickney!"

Discussion

The psychiatric consultant, in all his consultations with school personnel, both in the Pittsburgh Public Schools and with Project Upward Bound, has several objectives toward which his work is directed.

1. Teaching mental health concepts and principles
2. Teaching the historical method
3. Developing a heightened self-awareness on the part of all personnel who are working with children
4. Deepening the compassion and sensitivity of school personnel
5. Teaching interdisciplinary communication.

From the data presented in this report, it can be concluded that the psychiatric consultation to Project Upward Bound continues to follow the basic principles established in the Mental Health Services program in the Pittsburgh Public Schools. The response of 76 percent of those who received mailed questionnaires is extremely high, compared with usual expected returns of 10 to 20 percent. This may be an indication of the degree of involvement and identification with the consultation activity and with the psychiatric consultant himself.

The responses proved to be thoughtful and insightful. Many of them indicated that the participants of the consultation conferences had, themselves, perceived the objectives as described above, although they had never been made explicit, as such, to the group. Not only had the staff perceived the objectives, but their responses describe considerable movement toward their fulfillment. Some illustrations follow:

1. Teaching mental health concepts and principles

   "I have been able to apply much of the learnings about adolescent behavior obtained in college but never put to practice before Dr. Stickney tied the whole thing together."

   "I need to be reminded from time to time that behavior has causes. These discussions help to remind me."

   "I think the approach is primarily sociological with the emphasis on using existing strengths and health."

2. Teaching the historical method

   "The child's relationship to parents is very much emphasized...its transfer to the student-teacher relationship is often indicated."

   "Dr. Stickney always suggests or gets the staff to suggest why students behave as they do. We were always searching for reasons or causes."

3. Developing a heightened self-awareness on the part of the professional

   "I feel as though the sessions were designed to have the staff evaluate themselves."

   "I now try to understand the reasons why students behave as they do, and as a result, I have less of a tendency to be punitive and more of a tendency to be helpful."

   "I can endure unusual behavior and respond with more tranquility when I understand the cause."

   "Possibly the conferences helped the teachers more than they did the students. (I wonder if teacher help wasn't their aim.)"

4. Deepening the compassion and sensitivity of school personnel

   "I feel that I am more sensitive to people..."

   "Has created deeper sensitivity in me..."

   "It has given me greater insight into the problems of the kinds of young people in the Project."

5. Teaching interdisciplinary communication

   "Recognition of contributions that persons of different backgrounds can make toward finding assistance and possible solutions of problems that are very complicated."

   "One should gather as much information as possible, and from many sources."

   "I have developed an increased appreciation for teachers' observations of students..."

Recommendations for change included expansion of the consultation program and the development of carry-over into the schools.

It can be concluded from the data presented that the contribution of the psychiatric consultant proved to be effective and valuable. The consultation conferences were fulfilling their objectives, meeting the needs of the Project Upward Bound staff and were being received enthusiastically.

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April 1968

TWO STUDIES ON THE USE OF CORPORAL PUNISHMENT IN THE SCHOOL

Vivien Richman,
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ALTERNATIVES TO CORPORAL PUNISHMENT

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CORPORAL PUNISHMENT IN THE SCHOOLS

History

The Bible provides specific instructions on the use and efficacy of corporal punishment. "He that spareth his rod hateth his son." (Proverbs, 13, 24). "Smite his loins sore while he is little, lest he become stubborn and rebel against thee." (Ecclesiasticus, 13, 12). Corporal punishment was a salient feature of early Greek education. Education among the Spartans was designed to improve the military efficiency of the population. According to Boyd (1965), they developed a "very narrow outlook on life."

Plato believed that the child's character was molded by the total impact of his physical and moral environment. He recommended that the child be punished between the ages of 3 and 6, but without causing him shame and resentment. (Castle, 1962).

In the 16th century, with the advent of humanism in education, physical punishment was rare. The Jesuit system advanced the idea that learning must come from love of the teacher and the school, rather than from external coercion. Montaigne, in his Essay on Pedantry, wrote, "Harsh punishments degrade and dull a high-grade nature and destroy all desire for learning." (Boyd, 1965). In the 17th century, the educational philosopher, John Locke, stated, "Beating is the worst, and therefore the last means to be used in the correction of children." (Boyd, 1965). The following century brought the ideas of Pestalozzi to the fore, which produced the beginning of interest in child development. He did not object to punishment as such, but "to the principle that the children are punished when the master or the system is to blame." (Castle, 1962).

G. Stanley Hall, the Child Study movement, and the American educational philosopher John Dewey made the deepest and most lasting impression on the American educational scene, from the late 19th century to the present. Dewey, in particular, was a champion of the necessity for the school to educate our children for democratic living. In the case of discipline, he wrote of the importance of helping the child to become self-regulating. Generally, modern educational thought has shifted from the earlier view that misbehavior must be oppressed and suppressed, to the view that the child's needs must be met by the professional skills of the educator. Corporal punishment is forbidden by law in Austria, Holland, Belgium, Norway, Denmark, Italy, France and most of Switzerland, but continues to be used in the English-speaking countries and in Sweden. (Castle, 1962).

Statement of the Problem:

This paper will concern itself with an examination of the current practice of paddling children, as a disciplinary measure, in the Pittsburgh Public Schools. The official policy, as stated in the Rules of the Board of Education of the School District of Pittsburgh, are as follows:

> "Section 739 - Good judgement and proper caution must be used by principals or teachers in administering corporal punishment, and due regard must be taken for individualities of children. (Code - Section 1317)
>
> Section 740 - Teachers may, with the approval of the principal, use corporal punishment in the principal's office or that of the vice principal in the presence of the principal or vice principal. Its use by teachers in the classroom is forbidden except under the necessity of self-defense. (Code - Section 1317)"

Although it is recognized that this is only one form of disciplinary action, ranging from verbal rebuke to expulsion from school, the material presented here will be focussed primarily on paddling. This involves sending or accompanying the misbehaving child to the principal's office in the elementary school, or to the vice principal's office in the secondary school. The principal or vice principal, who may or may not have been directly or immediately involved with the child's misbehavior, may speak to the child about his offense, and then administer the paddling. The child is usually asked to put his hands on the desk during the administration of the punishment.

The questions raised by this presentation are:

1. Is corporal punishment effective in dealing with misbehavior in school?
2. Does the existence of corporal punishment in the school act as a deterrent to misbehavior?
3. Are there alternatives to corporal punishment which are expedient, practical and which are more effective?

The issue of "psychological" punishment, apart from corporal punishment, will not be dealt with at this time.

II. The Case for Punishment

While it was not possible to find, in the professional education literature, justification for the specific use of corporal punishment in the schools, there was material on punishment in general. Waller (1932) defines punishment as:

> "...a measured pain or inconvenience imposed according to rule by the representative of authority upon those subject to that authority." (p.200).

He points to two values of the use of punishment. First, it serves to define the situation. It clearly distinguishes acceptable from unacceptable behavior in school. If consistent, it sets up limitations which enable the student to adapt his behavior to them. Second, it removes the offender from the group, so that the authority of the teacher is left intact, and others are prevented from imitating his misbehavior.

In discussing techniques for creating and maintaining conditions of order in the classroom, Bagley (1907) writes:

> "Get order. Drop everything else, if necessary, until order is secured...Pile penalty upon penalty for misdemeanors, and let the 'sting' of each penalty be double that of its predecessor." (p.97).

Some learning theorists have examined the effects of punishment on learning. The role of punishment has rarely been explored in experimental studies of human behavior in social situations. "Punishment may have very diverse effects, depending on its timing, intensity and nature, and on the status of the punitive agent." (Bandura & Walters, 1965). Generally speaking, punishment by an authority figure, according to Bandura and Walters (1965), seems to inhibit direct aggression in the presence of the punitive agent. Studies in the timing of punishment, (Aronfreed & Reber, 1963; Mowrer, 1960a, 1960b) indicate that punishment administered early in a response sequence should more effectively prevent the actual misbehavior than punishment which is given only when the undesirable act has occurred.

Any disciplinary act may involve at least two operations, the presentation of a negative reinforcer (such as punishment), or the withholding of a positive reinforcement (such as threat of loss of love.)

In order to predict the outcome of punishment, it is also necessary to know the prior social-learning experiences of the person who is being disciplined. (W. Allinsmith, 1960; Grinder, 1962; Sears, Maccoby and Levin, 1957)

It has been indicated that in some circumstances, punishment can be effective in modifying behavior. In a chapter by Azrin and Holz (Honig, 1966), the method for arranging such punishment is described. The punishment must be as intense as possible; it must be introduced at the highest level of intensity, and maintained; it must be as frequent as possible, immediately after the undesirable response, if possible; and there must be no escape from the punishment. These conditions can hardly be met in a school situation.

Research indicates that punishment, used by itself, is not an effective habit-breaker. At best, it produces only a temporary suppression of undesirable behavior. However, if it is used in a situation that provides an alternative line of action, it may be effective in altering behavior. (Whiting and Mowrer, 1943).

Corporal punishment has the advantage of expediency. The practice of removing a disturbing child from the classroom enables the teacher to give her attention and skill to the others in the class. The punishment puts an end, at least temporarily, to the disturbing behavior. Some teachers and administrators sincerely believe that paddling is necessary and effective, and that without it, a serious drop in school personnel morale would occur. Some parents, particularly in the lower socio-economic areas, encourage the school to administer physical punishment when their children misbehave.

The problem of classroom management is further complicated by the presence of angry, hostile children in the school who may be, in effect, bearing messages from their angry, hostile parents. The school must react to these attitudes and attempt to control them.

III. The Case Against Corporal Punishment

1. Perhaps the strongest single argument against the continued use of corporal punishment is that it does not work. It does not eliminate undesirable behavior. It does suppress such behavior (Azrin, 1959; 1960; Estes, 1944), but it may sometimes result in generalized inhibition, involving responses other than the punished ones. (Estes & Skinner, 1941; Sidman, 1962). According to Kimble and Garmezy (1963),

> "...Punishment has its primary effect on performance and does not, in and of itself, influence habit very much. Practically, it means that the suppression of behavior by means of punishment must be a continuing process. One cannot punish a response a few times and then expect it to remain permanently inhibited. The effects of punishment wear off in time and the response will reappear." (p.252)

Woodworth and Schlosberg (1956) wrote, "...Repeated punishment for an act does not deprive that act of its inherent fascination." (p.674) Sexton (1961) observed that corporal punishment apparently does not work with a great many students, and in fact seem to have "an effect opposite to what is presumably intended." Similarly, Waller (1932) wrote:

> "...we may remark that punishment often fails to accomplish its purpose, even when the pains connected with it are multiplied far beyond any possible pleasure connected with a violation of the rules, because the causes from which offenses come are more deep-seated than the remedies superimposed, so that the only effect of punishment is to enhance mental conflict...It is not possible by punishment to produce very much effect on a deep-lying personal hostility, except to increase it, or to deal with an irrational, unconscious attitude of rebellion." (p.200).

2. Corporal punishment breeds further aggressive behavior, and provides an aggressive model for the student. This is substantiated by studies of Bandura (1960) and Bandura & Walters (1959), which report that children whose parents use punitive methods of discipline display little aggression towards their parents, but are highly aggressive in interactions with peers and adults outside their homes. Graham, Charwat, Honig and Weltz (1951) found that adolescents were more likely to fight back when they were the objects of a strong attack than when the attack made on them was weak. Sears, Maccoby and Levin (1957) report that children who have been treated aggressively and harshly, treat others in the same way.

3. It creates an unpleasant school climate. Kessler (1966) elaborates on this:

> "If the teacher becomes very angry, punitive or threatening... all the children become vicariously involved. The well-behaved child may become frightened or angry by the teacher's behavior toward the offending child. Even the best-behaved child has some feeling of kinship for the bad child in his midst." (p.494)

4. The existence of corporal punishment has in it the inference of a contract. The school agrees to "permit" certain undesirable behavior in exchange for a given number of "swats" with the paddle. And the contract, with some extreme exceptions, never ends.

5. Corporal punishment has been outlawed in the military, and even in our prisons. The fact of its continued existence in the schools expresses a basic disrespect for the person of the child.

6. Misbehavior is functional. (Dollard et al, 1939) It is frequently the result of a learning disability, of poor home conditions, physical reasons, an inappropriate curriculum, etc. which are not affected by the physical punishment.

7. It is antithetical to the teaching of democratic human values. The fact that teacher-training institutions teach alternative methods of classroom management, and that modern educational literature (Castle, 1962) condemns the practice of corporal punishment, reflects contemporary educational philosophy.

8. As long as corporal punishment continues to be used, school personnel may not be subject to pressure to invent new approaches to discipline. Paddling is self-perpetuating.

9. The use of the paddle usually means an indefinite postponement, by the school, and the child, and the family, of a confrontation with causes of misbehavior and appropriate remediation.

10. It is physically dangerous to the punisher, particularly with big, adolescent boys.

11. It has sexual overtones, particularly when a male administrator is paddling an adolescent girl. (Ellis, 1960)

12. For adolescent boys, it is confusing to them, to have the authority of society, which is vested in the school, represented by one-to-one aggression.

13. The correction of a child's behavior is a responsibility which should be shared by the home, the school and other community agencies. Rather than solitary action, like paddling, the school should involve the home and the community in constructive help for the misbehaving child.

14. Studies have shown that the threat of capital punishment has not been an effective deterrent to crime. It is not reasonable to expect that corporal punishment will deter misbehavior.

15. To children who are regularly and frequently the recipients of severe and brutal physical punishment at home, paddling in school is relatively meaningless.

16. In times of racial tension, corporal punishment is a provocative action to the community. Sexton (1966) reported a study by Abrahamson (1952) of 705 seventh, eighth, and ninth grade students in six communities. Lower class students got most of the punishment. According to the teachers themselves, "...when it came to handing out disciplinary measures, there was a tendency for the students of lower social class backgrounds to receive much more than their share..."

Kessler (1966) wrote:

> "Stern punishment is still viewed by some as the only solution for badness, despite overwhelming evidence to the contrary."(p.328)

A final note should include some reference to the objectives of corporal punishment, or, for that matter, of any discipline in the school. Castle (1962) has written:

> "Freedom, I suggest, is the condition in which the self-disciplined man lives. The self-disciplined man is the man who thinks and acts within the boundary of certain limitations...Thus, the conditions of freedom are achieved by means of a discipline which we ultimately impose on ourselves and call self-discipline.

> "But this is almost certainly an end-product of external discipline... It is most important to regard this external discipline not only as a group of thou-shalt-nots, but also as a subtle complex of encouragement, guidance and suggestion that helps to build up self-confidence in children...
>
> The point to note here is that external discipline should never be an end in itself, but always a means of developing self-discipline in those who are subjected to it. Obedience and punishment are merely means to self-discipline.
>
> Obedience to adults which merely invites revolt, and punishments that are merely retributive, are pointless in the end, even if useful at the time. Further, we may insist on obedience and we may punish, but neither obedience nor punishment will help a child to govern himself unless ultimately, not necessarily at once, he accepts them as relevant to what he wants to do or wants to be.
>
> ...But obedience to others is not enough. Older children must learn to obey themselves, for it is at this point that discipline, obedience and personal responsibility begin to play on one another in subtle ways.
>
> They must be made to feel obligation, which they cannot do unless they are actively engaged in being responsible...This is the object of moral education."

Summary

Let us re-state the central issue at this point. The question at hand is not whether to punish or not to punish. Obviously, any society must have order, rules and limits. The question is: how do we best achieve and maintain order?

Have the questions raised on Page 2 been answered by this presentation?

1. Is corporal punishment effective in dealing with misbehavior in school? The evidence presented here would indicate that it is not.
2. Does the existence of corporal punishment in the school act as a deterrent to misbehavior? Again, the arguments show it may not.
3. Are there alternatives to corporal punishment which are expedient, practical, and which are more effective?

It is to this last question that the balance of this report is directed.

IV. Alternatives to Corporal Punishment

1. The state of New Jersey has recently passed legislation outlawing the use of corporal punishment in the schools. It would be helpful to find out what constituted the basis for their decision to act, and what alternatives they are employing.

2. For any new approaches to classroom management to be successful, it would seem to be imperative to involve teachers, principals, administrators, and parents in dialogues leading to cooperative, creative planning.

3. The Mental Health Services staff, in working with a Junior High School, has successfully implemented a "share-the-misery" plan. When a child's behavior was disruptive, he was told, in the presence of his parents, that such behavior was unacceptable to the school, and he was put on a half-time schedule until he could conform to school regulations. After 5 or 6 of such actions, the "word" got around to the student body that the school would not tolerate bad behavior, and they settled down.

4. Perhaps on a voluntary basis, several elementary schools would offer to function as demonstration schools, without corporal punishment. (The elementary school principals in Homewood-Brushton who met with Dr. Stickney may be interested.)

5. The need for early intervention is apparent and urgent. The earlier a child learns, in his school life, what constitutes appropriate school behavior, and the earlier that remediation is applied to the contributing causes of misbehavior, the less difficulty the child and the school will encounter later.

6. A program of parent education would be imperative and would serve several purposes. Parents could be taught explicitly what kind of behaviors are clearly unacceptable to the school and the consequences for them. For those who are angry with the school, proper means of dissent could be described.

7. An in-service education program for teachers, principals and other relevant school personnel should be developed, dealing with practical aspects of classroom management and discipline. (The NEA monograph on discipline techniques may be helpful.)

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REFERENCES

Abrahamson, S. Our status system and scholastic rewards. J. educ. sociol. 25,8, 1952.

Allinsmith, W. The learning of moral standards. In D.R. Miller and G.E. Swanson, Eds. Inner conflict and defense. N.Y. Holt, 1960.

Aronfreed, J. & Reber, A. The The internalization of social control through punishment. In A. Bandura and R.H. Walters, Social learning and personality development, Holt, Rinehart & Winston, Inc. N.Y. 1965.

Azrin, N.H. Punishment and recovery during fixed-ratio performance. J. exp. anal. Behav. 1959, 2, 301-305.

Azrin, N.H. Effects of punishment intensity during variable-interval reinforcement. J. exp. anal. Behav. 1960, 3, 123-142.

Bagley, W. C. Classroom management, Macmillan Co. N.Y. 1907.

Bandura, A. and Walters, R.H. Social learning and personality development. Holt, Rinehart & Winston, Inc. N.Y. 1965.

Bandura, A. Relationship of family patterns to child behavior disorders. Progress Report, U.S.P.H. Research Grant M-1734, Stanford U. 1960.

Bandura, A. and Walters, R.H. Adolescent aggression. Ronald, N.Y. 1959.

Boyd, W. The history of Western education. Barnes & Noble, N.Y. 1965.

Castle, E.B. Educating the good man; Moral education in Christian times. Collier Books, N.Y. 1962.

Dollard, J., Doob, L.W., Miller, N.E., Mowrer, O.H. & Sears, R.R. Frustration and aggression. New Haven, Yale Univ. Press, 1939.

Ellis, Havelock, Psychology of Sex, New York, Emerson, 1960.

Estes, W. K. An experimental study of punishment. Psychol. Monogr. 1944, 57, No. 3.

Estes, W.K. & Skinner, B.F. Some quantitative properties of anxiety, J. exp. Psychol. 1941, 29, 390-400.

Grinder, R.E. Parental childrearing practices, conscience, and resistance to temptation of sixth grade children. Child Develpm. 1962, 33, 803-820.

Honig, W.K. (Ed.) Operant Behavior. Appleton-Century, N.Y. 1966.

Kessler, Jane W. The psychopathology of childhood. Prentice-Hall, Inc. N.J. 1966.

Mowrer, O.H. Learning theory and behavior. N.Y. Wiley, 1960 (a)

Mowrer, O.H. Learning theory and the symbolic processes. N.Y. Wiley, 1960(b).

Sexton, Patricia C. Education and income. Viking, N.Y. 1961.

Sidman, M. Operant techniques. In A.J. Bachrach, (Ed.) Experimental foundations of clinical psychology. N.Y. Basic, 1962.

Waller, W. The sociology of teaching. Wiley, N.Y. 1932.

Whiting, J.W.M. & Mowrer, O.H. Habit progression and regression. J. comp. psychol., 1943, 36, 229-253.

Woodworth, R.S. and Schlosberg, H. Experimental psychology. Holt, N.Y. 1956.

SOME ALTERNATIVES TO THE USE OF CORPORAL PUNISHMENT IN THE SCHOOL

The purposes of this report are to review the educational literature concerning current practices in discipline, and, further, to summarize positive, workable alternatives to the use of corporal punishment in the public schools.

A national survey made by McGraw-Hill World News (Hickman, 1965) reported that, although 49 states permit corporal punishment, most school districts approach it warily. Some prohibit it, and the majority of districts restrict its use to "last resort" situations only. The prevailing view in the public schools is: "Corporal punishment is not wise; where permitted, it is not recommended; when used, it is only after all else has failed; when applied, it must be administered carefully." (p.48).

Kansas City, Mo. has four key rules governing the practice of corporal punishment which are almost always found in other school districts:

1. Parents have specifically given permission to the school, previous to the administration of the punishment,
2. It is to be administered only by the principal, in the presence of school staff witnesses,
3. It is never administered on or about the child's head,
4. A written report is sent to the Superintendent of the district.

Parental consent is essential in Minneapolis, Minn., Birmingham, Ala., Bellevue, Wash., DeKalb, Ga., and Berkeley, Calif. In Portland, Me., a written report is sent to the Superintendent's office within 24 hours, while in San Francisco, Calif,, such reports are submitted on a monthly basis.

A study conducted by the NEA Research Office (1956) reported that corporal punishment had no effect in reducing behavior problems in the classroom. Nash (1963) wrote an eloquent and well-documented article against the continued use of corporal punishment, in which he wrote:

> "Violence feeds upon violence. It is impossible to isolate it once we embark on it, and we are now aware of the ultimate consequences of violent behavior in our power to destroy completely the species of man." (p.307)

In providing some perspective for our examination of the problem, Margaret Mead (1959) described the revolution in child care which has occurred in this country in the last 25 years. Fear and punishment have largely been rejected as part of the adult authority system. Emphases are now on the teaching of responsibility to the young, and on the relationship between the self and the needs of the situation.

Commenting further on contemporary problems of the schools, Chamberlin (1967) took note of the rising age of compulsory school attendance. He pointed out the shift in emphasis in the school from education for citizenship to science and mathematics, in order to train technical skills. He also identified economic and social pressures in our society which are directed toward keeping the student out of the labor market and in school until he develops salable skills.

> "Not all students agree with the goals that have been established for them. Conflicts naturally result from this and teachers and administrators have the resulting discipline situation to contend with." (p.295).

The NEA Research Office conducted a national opinion poll of teachers with more than five years of teaching experience. Forty-five percent of the respondents believed that maintaining discipline in the school was more difficult than when they began their teaching careers; thirty-four percent believed it was about the same; twenty-one percent felt that it was easier. When the responses were classified according to years of teaching experience, however, the results were as follows:

	5 to 9 years	10 to 19 years	20 or more years
More difficult	25	44	62
About the same	43	35	25
Easier	32	21	13

The highest proportion of teachers who found the maintenance of discipline more difficult occurred among those with twenty or more years of teaching experience (62 percent). Only 25 percent of the teachers with five to nine years of experience found it more difficult. It is not clear from the research whether this discrepancy is due to differences which occurred in the past twenty years in school climate, emerging social problems, and expectations of the school, or whether it represents more rigidity and less communication with today's children on the part of the older teachers.

Delaney (1965) commented on the tendency of some school people to insist on equating a quiet school with a well-disciplined school. He believes that a measure of noise must necessarily accompany learning activities among children.

> "The administrator who walks down a corridor of silence had better be suspicious. Seldom is there learning in a tomb." (p.371)

In a fifteen-year study of schools in the United States and in fourteen countries in the Middle East and in Europe, discipline was the chief concern in 95 percent of the schools visited and among 98 percent of the teachers interviewed. The majority of the opinions expressed by school personnel were against the use of corporal punishment. (Vredevoe, 1965).

Studying the records of high school students who were behavior problems, Farragher (1964) found that many of them had demonstrated disturbed behavior as early as kindergarten or first grade. He recommended early identification of these children and some remedial intervention.

What is Good Discipline?

Good discipline is not punishment. It involves setting up clear educational and behavioral goals and finding ways to implement them. Good discipline is systematic, ordered learning which contributes to achievement and good mental health. It should be corrective, and it should point out the positive alternatives that are available to the child. (Phillips et al, 1960).

Ojemann (1962) elaborated on the importance of teaching the student to examine alternatives. He added that the student must experience the consequences of his actions in order to learn how to make intelligent choices. The goals of discipline are self-direction and, eventually, self-discipline. (Hockstad, 1962).

How Can it be Achieved and Maintained?

The educational literature which is concerned with the establishment and maintenance of good discipline falls into two broad categories: general recommendations based on principles, and specific techniques for good classroom management. This report will summarize the general recommendations and follow them with specific techniques.

General Recommendations

Marsico (1964) enumerated four prerequisites for the establishment of good discipline:

1. The school must teach and re-teach appropriate school behavior.
2. The teacher must feel that the misbehaving child can be helped.
3. The teacher must believe that misbehavior is not a personal affront.
4. The teacher must recognize that the misbehaving child is sending a message for help.

The fifteen-year study of schools in the United States, the Middle East and Europe, which was referred to earlier in this report (Vredevoe, 1965), listed several practices which were effective in developing good behavior in school:

1. Clear understanding of standards and rules
2. Emphasis on self-discipline by both teachers and students
3. Courtesy, consideration and respect practiced by the faculty
4. Rules subject to review and change, but enforced until changed.
5. Fairness, with emphasis on the individual, not on the undesirable action
6. Cooperation of teachers and students in establishing, maintaining and revising the rules.

The development of a law-abiding spirit and a spirit of industry were recommended by Gans (1965). Honest leadership on the part of the faculty, the use of group evaluation and the development of a good teaching voice were suggested. He included three "don't's": don't correct a child publicly; don't be vindictive; don't prolong the incident.

Consequences of behavior should be described to the child in advance of his actions. The child should be provided with academic assignments which are within his range of ability. (Phillips et al, 1960). The most successful prevention measure is work, with the student working within his capabilities. Discipline problems can be avoided with proper planning and preparation on the part of the teacher. (Christy, 1962).

Student behavior should not be examined in isolation. It must be considered as part of an interaction with other variables. Increased self-awareness on the part of the teacher deepens the understanding of such interactions and indirectly contributes to better classroom management. (Muuss, 1963).

Specific Recommendations and Techniques

An effective technique is to isolate the misbehaving child in another room where he is to continue his school work. He may return to class when he feels ready to conform to class standards. (Phillips et al, 1960). This is effective particularly if the classroom situation is task-oriented so that the child dislikes being removed from the class. The use of a "stand-by officer", someone to be available to the teacher on short notice to take the child to a quiet room, is recommended by Blom (1966).

The misbehaving child may be sent home. This stops the disturbing behavior and demonstrates the consequences of asocial behavior. (Phillips et al, 1960). Wilkinson (1960) listed several suggested measures designed to achieve positive discipline through associating the punishment with the misdeed:

1. The pupil writes a paragraph explaining what happened.
2. The pupil reports to the class what happened and why.
3. The pupil stays in school to complete the work which was not done during the time that was wasted.
4. The pupil makes a report to his parents and has them call the school.
5. The pupil is isolated from the class.
6. Physical punishment may be used only when the pupil does not respond to anything else.

He suggested that any students who do not respond to these alternatives need clinical assistance and are beyond the capabilities of the teacher.

Kirman (1964) and Ornstein (1967) turned their attention to practical techniques for maintaining good discipline in difficult schools, particularly in communities of low socio-economic levels. Kirman cautions against using middle-class threats or middle-class disciplinary methods, such as poor marks, with children who are identified with another value system. He recommended that good conduct and good work should be given recognition and reward, perhaps by sending a certificate of commendation to the parents of the child who earned it.

Ornstein (1967) listed several practices which he advocates for the maintenance of good discipline among disadvantaged children:

1. Train the students to enter and leave the room in an orderly fashion
2. Keep the room clean and attractive
3. Be sure to have everyone's attention before starting the lesson
4. Develop a consistent class routine
5. Get to know the children as quickly as possible
6. Hold them accountable for their actions
7. Give clear instructions

Batchelder (1964) reported twelve alternatives for action by school personnel. These were used as the basis for faculty meetings in secondary schools and for classroom discussions with the students. The advantages and disadvantages of each method were explored. The methods described were:

1. Simple control: mild reproof, teacher's movement
2. Individual conference with the pupil
3. Home-school cooperation and co-action
4. Restitution and reparation by the student for damages
5. Loss of privilege
6. Rewards and prizes
7. Detention after school
8. Dismissal from class and isolation
9. Lowering marks
10. Corporal punishment
11. Suspension
12. Expulsion

In a statistical study of discipline, Celler (1951) examined the teaching practices of 82 junior and senior high school teachers, in terms of their classroom management. It was found that the use of specific practices contributed substantially to the maintenance of good classroom control:

1. The practice of using all available equipment and visual aids to enrich a lesson is closely associated with effective discipline.
2. The practice of routinizing certain classroom procedures, such as the distribution of paper, is also helpful.
3. The practice of presenting the subject in a vital and enthusiastic manner, of making the subject matter appealing to the point that interest and enthusiasm catches on, is very effective.
4. Other practices, such as avoiding lulls or idleness, and the use of simple devices, proved to be effective.

The Philadelphia Public Schools issued three bulletins to their staff, titled "Discipline for Constructive Citizenship". (Boodish, 1956). The following punishments were approved as successful practices:

1. Expression of disapproval in private, later, if necessary, in the presence of the group,
2. Temporary isolation under supervision,
3. Detention for specific purposes which are clearly stated and achieved during the detention,
4. Withdrawal of privileges.

A very interesting "experiment" was reported by Voorhees (1954). Every teacher in a high school kept a tally of infractions of rules and other student misbehavior. At the end of four weeks, they had counted 291 incidents. A student meeting was called, this information was shared with them and the problem became a joint concern of students and faculty. A committee of 10 students was formed, five elected by the students and five appointed by the faculty, to meet and discuss solutions and alternatives. Six weeks later, the teachers, in a four week period, counted 192 infractions, a considerable reduction.

In a survey conducted in California (Barnes, 1955), it was found that the most commonly used disciplinary measure was a conference by the vice principal with the student. The second most commonly used was the parent conference. The consequences of the destruction of property were usually a conference and payment for the damage by the student. For specific infractions, the following disciplinary measures were reported:

Truancy: conference with attendance office, referral to attendance officer, adjustment of program, restriction of privileges, referral to Juvenile Court, demerits, case conference, transfer to regular or special school, student court, probation officer, referral to principal, expulsion.

Forgery: conference with attendance officer, home visit, demerits, case study, note in cumulative record, student court, counselor, transfer.

Theft: Referral to counselor, to psychologist, letter to parents, transfer class, transfer to regular or special school, restitution.

Smoking: Help from physical education and science teachers, student supervisor of lavatories, student court, letter to parents, referral to principal, to counselor, transfer.

Profanity: student conference, dismissal from class or team, apology, restriction of privileges, teacher-parent conference, referral to principal.

Defiance: Teacher-parent conference, removal from class, referral to principal, ineligibility for certain activities.

The judicious application of appropriate disciplinary measures should, of course, match the degree of misbehavior. The table on the following page is an attempt to demonstrate the application of some of the actions recommended in this report across a continuum of undesirable behaviors.

Destruction of people, property	Overt disrespect toward teacher or authority	Infraction of School rules	Infraction of class rules	Disobedience of direct order	Unwilling to work	Disrupting class, talking
1. Home-school cooperation and co-action.	1. Home-school cooperation and co-action.	1. Pupil writes paragraph to explain what happened.	1. Pupil writes paragraph to explain what happened.	1. Home-school cooperation and co-action.	1. Individual conference with pupil	1. Simple control, mild reproof.
2. Restitution and reparation by student for damages.	2. Pupil is isolated from class	2. Loss of privilege	2. Pupil reports to the class what happened and why.	2. Individual conference with pupil.	2. Referral for help	2. Individual conference with pupil.
3. Suspension and conference with parents.	3. Pupil makes a report to his parents and has them call school.	3. Individual conference with pupil.	3. Dismissal from class and isolation	3. Loss of privilege.		3. Loss of privilege.
		4. Suspension and conference with parents	4. Pupil stays in school to complete work not done during time wasted.	4. Dismissal from class and isolation.		4. Detention after school.
						5. Dismissal from class and isolation.

It is curious that almost nowhere in the literature is the suggestion made that ancillary services may be required. Referral to school social workers, psychologists, therapists, remedial teachers or mental health professionals is apparently not considered in dealing with behavior problems. These are resources which should be utilized, when it seems appropriate.

Summary

It can be seen from the material summarized in this report that there exists a wide range of positive, workable alternatives to the use of corporal punishment in the schools. Where corporal punishment is practiced, it is highly restricted and controlled. Parental consent and written reports to the Superintendent are required in many districts.

Many of the classroom management methods are rooted in good teaching techniques, coupled with consistency, common sense and flexibility. Learning is most likely to occur when there has been adequate preparation and planning on the part of the teacher, and when the classroom climate is organized and orderly. Establishing and maintaining such a climate is the primary task of the teacher, and can be accomplished, as was shown in this report, in a variety of ways.

Further, one could speculate that, if the commitment were made to abolish the use of corporal punishment, school personnel in the Pittsburgh Public Schools would be able to contribute many additional positive management practices from their own experience.

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REFERENCES

Barnes, Thelma. Administrative techniques in handling discipline. California Journal of Secondary Education, 30: 437-439, 1955.

Batchelder, H.H. Corrective measures, punishment and discipline. Journal of Secondary Education, 39: 86-93, Feb. 1964.

Blom, G.E. Psychoeducational aspects of classroom management. Exceptional Children, 32: 377:83, Feb. 1966.

Boodish, H.M. The teachers' page. Social Studies, 47: 72-75, 1956.

Chamberlin, L.J. Discipline and the public school. Education, 87: 292-295, Jan. 1967.

Christy, T.J. Classroom control. School and Community, 49: 7, Sept. 1962.

Delaney, A.A. Tomb or classroom? Clearing House, 39: 370-371, Feb. 1965.

Farragher, M. Anti-social child and the school. School Review, 72: 472-489, Winter 1964.

Gans, R. Five steps toward good classroom discipline. Grade Teacher, 83: 71, Sept. 1965.

Hickman, L.C. Corporal punishment - relegated to last resort discipline. Nations Schools, 76: 48-50, Dec. 1965.

Hockstad, P. Classroom discipline. Education, 82: 410-415, March, 1962.

Kirman, J.M. Teacher survival in difficult schools. High Points, 46: 69-70, April 1964.

Marsico, A. Control without punishment. High Points, 47: 9-19, Winter 1964.

Mead, Margaret. New kind of discipline. Education Digest, 25: 13-15, Dec. 1959.

Muuss, R.E. First aid for discipline problems. Education Digest, 29: 36-38, Nov. 1963.

Nash, P. Corporal punishment in an age of violence. Educational Theory, 13: 295-308, Oct. 1963.

NEA Journal, Classroom discipline; teacher opinion poll, 53: 25, Sept. 1964.

NEA Research Bulletin #34, April 1956, p. 89, referred to in Nash, P. (see above)

Ojemann, R.E. What kind of discipline for adolescents? Education Digest, 27: 32-34, May 1962.

Ornstein, A.C. Techniques and fundamentals for teaching the disadvantaged. Journal of Negro Education, 36: 136-145, Spring 1967.

Phillips, E.L., Wiener, D.N. and Haring, N.G. Discipline, Achievement and Mental Health. N.J. Prentice-Hall, Inc. 1960.

Voorhees, L. Solving high school discipline problems. National Assn. of Secondary School Principals Bulletin, 38: 61-65, 1954.

Vredevoe, L.E. School discipline; 3rd report on a study of students and school discipline in the U.S. and other countries. National Assn. of Secondary School Principals Bulletin, 49: 215-226, March 1965.

Wilkinson, F.F. Positive discipline. Instructor, 70: 15ff. Oct. 1960.

ALTERNATIVES TO CORPORAL PUNISHMENT

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There are several things the Mental Health Services are now doing that qualify as alternatives to corporal punishment. The first is to have the principal and teachers, with the aid of the school social worker and the Mental Health Services consultant, look into the causes of the child's behavior. If it arises from an intolerable home, or if the parents are permitting or encouraging the misbehavior, it is pointless to beat the child. One must work with the parents.

A concrete method for doing this is for the principal to have a conference with the parents and child and arrange for the child to be on a half time schedule for a few weeks, or several months. At this point the parents will rally to the child and help him, if they can, and his behavior at school will settle down. If not, if they can't or won't, his behavior will worsen and the child will soon be placed for a time outside the home and in a residential school. Meanwhile, the teacher gets some relief from the child and vice versa.

If in a reasonable period the child can't shape up enough to be containable at school, or at another school -- we often try him in another school first -- then a medical excusal often has the effect of expediting other child care services to the child and his family, e.g., via Child Welfare or Juvenile Court.

Some schools are intolerable for, and intolerant of, certain types of children. When we discover this, we try to transfer the child, as it is a prolonged and uncertain task to modify the attitudes and behavior of the principal and teachers of that school.

Another approach to disciplinary problems that we are suggesting, but have not implemented, is the fair trial for children accused of offenses. This is almost unheard of, but I learned of one at the Mt. Mercy Upward Bound Program. An accused child has the choice of one faculty member and one or two students to defend him before a trial board, which hears both sides and reaches a verdict. An alternative, which I also recommend, is to have a public defender or Ombudsman in each school. At present, children are surrounded by prosecutors, but have no public defender.

There are advantages to having a public defender in each school. If the difficulty is caused by the teacher who can't deal effectively and fairly with a child, this is brought out in the hearing. If this should happen repeatedly, it would then be open knowledge to the principal and the public defender, and hopefully something might be done to help the teacher to change his ways of treating students.

Perhaps the chief advantage would be to teach the children democratic principles and due process in action. At present we teach it in books, but not by example, for we expect children to accept our control of their behavior, but we don't often provide a fair hearing when the child's behavior conflicts with rules or with his teacher's personality. Law and order in the schools becomes far more palatable to children when it is tempered with compassion and fairness. Limits and discipline in themselves will not meet the needs of the children and the schools. An angry teacher and an overburdened vice principal or principal -- the customary participants in a "disciplinary problem" with the child -- are in no position to be the child's advocate, so he mostly has none. The open disrespect of many children for authorities, police, law and order, may well have some basis in the reality they encountered in school.

Another alternative that we use for children in conflict with authority is to try them in an Adjustment Class or Resource Room, part or full time. If this doesn't help after one or two semesters, we can usually assume that the child's home life is so disturbing that special help at school won't help him enough. In that case we try the sequence of half time, medical excusal if necessary, and placement in a residential school.

The school system urgently needs a residential school as an integral part of the whole public school system. Examples would be Shallcross School in Philadelphia, and the Re-Education Projects of Nashville, Tennessee, and Durham, North Carolina. The Re-Ed Projects have been so successful with difficult children over the past eight years that the Tennessee and North Carolina legislatures have voted the funds to have four or five such facilities in their respective states. Pennsylvania might do well to study and follow their example. Their approach deals with the multiple personal and environmental causes of misbehavior and learning problems in children, which is a refreshing and effective departure from the practice of beating the child in an effort to control behavior which may be uncontrollable until its causes have been dealt with.

A perennial source of misbehavior by students, aside from that which is taught by their parents, is misbehavior by teachers and administrators. This boils down to a failure, under long and recurrent stress of large classes and over-crowded tumultuous schools, to treat students with the same courtesy and respect that is due to an adult. Shouting at them, manhandling them, or calling them names are common practices. They won't work any more than the indignity of paddling will, and they do provoke the more independent and volatile children to further rebellion. The best teachers I have seen deal with student misbehavior firmly and fairly, without offering any discourtesy to the student. This attitude is respected by most children, and if it doesn't work, the problem is one for the parents and other child-caring institutions outside the school system.

We have at present no good method of dealing with the teacher whose exhaustion and personality traits make him destructive to, and a bad example for children. Perhaps we should beat him? It is curious that child-rearing couples freely recognize their inability and unwillingness to spend all their adult lives raising small children or even adolescents. Parents "burn out" on the job after they are 35 to 45 years old, but no such admission, and no such charity is given to the teachers. Many teachers do continue on the job for years past the time when they had the youth, strength, patience, warmth, and enthusiasm that are required for teaching young children. Their failures with children aged five to twelve turn up regularly as impossible disciplinary problems in junior high and high school.

So, the issue of corporal punishment, when closely considered, soon broadens into the issue of what to do to improve the schools.

Unless we improve pension and retirement plans, expand unemployment insurance for teachers, or drastically revise the tenure regulations, we will always have burnt-out teachers who create problems with children. Under present arrangements we can't insist upon treatment for teachers or remove them from teaching without severe financial loss to the teachers. I suspect that even the most expensive alternative would not be as costly as the one we have allowed to develop. It is the children who pay for the teacher's illness or exhaustion.

In a similar vein, how many problems are created by a stand-up-and-lecture system that requires children to sit still in rows and not speak? The evidence is, quite a few. For at least ten years, the elementary schools in England (see the Joseph Featherstone articles) have used a system that can't be described as "permissive", but allows far more freedom and communication to the children. Curiously, they have very few disciplinary problems or reading problems, while we continue to have large numbers of both. Meanwhile, for obscure reasons, we have abolished recess.

Close by in Baldwin-Whitehall we have the example of the Oakleaf School, where individually prescribed instruction, freedom of movement, and flexible climate from the top down, have produced similar results. This example, and ungraded schools wherein the custom of publicizing a child's level and rate of learning (e.g., publicizing his "failure") has been abolished, both seem to offer a decrease in behavior problems and an increase in zest for learning. In some high schools where modular scheduling has been tried, similar results have appeared, e.g., a decline in behavior problems and an increase in the spontaneous use of the library and information centers.

In summary, it is not a question of "To beat or not to beat," but one of looking honestly at the aspects of child behavior that are caused by the home, school, and community. I am in favor of teaching teachers the latest methods in behavioral modification as advocated by Doctors Shaffer and Scott. I think they would agree with me that much more is needed. If a child's behavior is symptomatic of something wrong in the home or the school, it would be very poor medicine just to control the symptom for the sake of order in the classroom.

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CHILDREN WHO DON'T LEARN:

SOME THEORETICAL CONSIDERATIONS

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CHILDREN WHO DON'T LEARN:
SOME THEORETICAL CONSIDERATIONS

The problem of children who are not learning in school has received considerable attention in this country during the last two decades. There was a time when children with school problems were thought of as being "bad" and were punished accordingly. Others may have regarded them as being lazy or uncommitted to learning, and attention was given to increasing their motivation. Recent evidence collected by Vinter and Sarri (Thomas, 1967) demonstrated, however, that this was not the case. Non-achievers were not lacking in motivation, but in skills.

With the rising age of compulsory school attendance, the school has been legally bound to contain and educate all the children in the community, usually until they reach the age of sixteen or seventeen. Further, the school requires that all the children internalize and pursue the goal of academic success and conform to some standards of conduct. (Schafer, 1967).

Depending on the theoretical orientation from which the problem is viewed, the children who do not learn are classified in a variety of ways: emotionally disturbed, disadvantaged or culturally deprived, socially maladjusted, neurologically handicapped, educationally handicapped, children with minimal brain damage, with perceptual-motor dysfunction, or with learning disabilities. If these children, as a result of their unsuccessful careers in learning, develop other socially undesirable behaviors, they may also be classified as truants, drop-outs, delinquents and unemployables.

How a problem is defined, by whom, and according to which theoretical orientation, then, will determine the treatment prescribed, and how and by whom it will be administered. The chart on the following page will illustrate the range of different treatments available for dealing with the child who does not learn. It can be seen easily that the definition of the problem, the identifying category in which it is placed, and the underlying theoretical orientation will determine, to a large degree, the nature of the treatment and the professional personnel required to administer it.

In planning and developing a mental health program for children, therefore, it must be recognized that selection of the theoretical basis will dictate the nature and delivery of service. The orientation must also be broad enough so that as many of the complex variables as possible will be affected by the resulting program.

Identifying Category	Theoretical Orientation	Treatment	Source of Treatment
Emotionally disturbed	Psychiatry, psychology, psychiatric social work	Psychoanalysis, psychotherapy, case work	Psychiatrist, psychologist, social worker
Disadvantaged, culturally deprived	Sociology, educational sociology, community organization, education	Social change, compensatory education programs, curriculum change	Sociologist, community organizer, school personnel
Socially maladjusted	Social work, group dynamics	Group work, case work, counselling	Social worker, guidance counselor
Neurologically handicapped, minimal brain damage	Neurology, Medecine, Special Education	Medication, physiotherapy, special teaching techniques	Neurologist, physician, physiatrist, special teacher
Perceptual-motor dysfunction	Child development, perceptual development theories, optometry	Prescribed remedial techniques to improve perception	Optometrist, perceptual-motor development consultant, technician, teacher
Educationally handicapped	Education, learning theory	Remedial teaching techniques, equipment and material	Special remedial teacher
Learning disability	Multi-discipline approach: education, social work, preventive psychiatry, psychology, learning theory	Re-training or re-education Teaching the child to learn how to learn.	Team: psychiatric and social work consultants, teacher, psychologist, school social worker, counselor and others
Truant, drop-out	School social work, law	Case work, counseling, legal sanctions	School social worker, counselor, court worker
Delinquent	Law, social work	Referral to correctional institution, probation, case work	Legal personnel, correctional personnel, social worker
Unemployable	Economics, social work	Welfare, re-training	Public assistance worker, teacher

This paper will select and discuss two possible theoretical approaches to dealing with the child with learning problems, and the consequent implications for treatment and the delivery of services. One approach will be that of the psychiatric clinic for children, formulated according to psychoanalytic theory. The other approach to be considered will be more eclectic, resembling the "learning disability" category on the chart, and involving the integration of several theoretical bases.

Application of Psychoanalytic Theory

It must first be assumed that the child with a learning problem, and his family, have been identified as being in need of psychiatric treatment. The next assumption to be made is that the child will be among the 5% of the children referred for psychiatric treatment in Allegheny County who actually received it, having survived the waiting lists and the intake procedures. (HWA, 1967).

Generally, therapy is concerned with using the influence of the therapist to help the patient to unlearn maladaptive behavior patterns and to learn better ones. Methods may include free association, the client-centered interview and progressive relaxation. (Frank , 1967). The problem resides primarily in the child and he is the major recipient of the treatment. Although the parents may be involved in concurrent case work treatment, the focus remains with the child.

The psychiatrist is primarily concerned with the underlying problems producing the symptoms, rather than merely eliminating the symptoms. Early symptom recession is regarded as a result of transference which tends to ease distress. (Coleman,1967). It is believed that, through successful treatment of the causes of the child's difficulty, the maladaptive behavior will disappear or diminish in frequency and intensity.

Learning problems in school are affected indirectly, through treatment of the child's psychological integration. In a sense, therapy is an educative, or re-educative process, but the methods employed are derived from psychoanalytic theory rather than from learning theory.

After the termination of treatment, the child must then be helped to change his role to that of a healthy, normal child. This transition is handled by the psychiatrist, sometimes with the assistance of a social worker, the family, school personnel or significant others in the child's life.

An Eclectic Approach

The Mental Health Services program (MHS) of the Pittsburgh Public Schools will serve as a demonstration of the application and integration of several theoretical positions. The following disciplines are involved: preventive psychiatry, psychology, education (regular, special and remedial), social work, learning theory, sociology, perceptual-motor development theory, and child development.

Under a three-year grant from the Maurice Falk Medical Fund to the Pittsburgh Public Schools, the MHS program was conceived to meet the mental health needs of the 95% of the children in Allegheny County who would otherwise receive no treatment. The establishment of a traditional psychiatric clinic in the schools was avoided for several reasons:

1. The scarcity of mental health professionals would lead to swift inundation of clinic facilities and the development of waiting lists.
2. A psychiatric-medical clinic would be regarded by the school as a "foreign body" in its midst, taking up valuable space and operating in non-educational terms.
3. Differing from traditional psychiatric treatment, the school is primarily concerned with the amelioration of symptoms, i.e. the child's learning difficulty, than with etiology, about which it can do little.

There are four major components in the MHS program: crisis consultations throughout the school system, special classes, regularly scheduled consultations to support the classes, and in-service education of school personnel. The consultation conference method which was developed by the MHS staff illustrates the multi-discipline approach which characterizes the program.

Participants usually include the MHS psychiatrist and social worker, the teachers who know the child under discussion, the school social worker, the principal, counselor, psychologist, school nurse or physician and any other personnel who have information to contribute. Representatives of other community agencies are frequently in attendance.

The conference is teacher-centered, with primary attention given to the teachers' first-hand observations of the child's daily behavior, and the identification of specific learning problems. The school social worker contributes information concerning the family history and a developmental history of the child. If the child has been tested, the psychologist may present the findings. Technical language is avoided, as all the information about the child is brought together in an effective and economical fashion.

The MHS consultants evaluate the material presented, examine the ecology of the child in the school, in his family, and in the community, and, with the other conference participants, develop a management-treatment-education plan of action. This plan is reviewed from time to time and appropriate alterations are made if necessary. The conference also serves the important function of being a training vehicle for all the participants.

If it is believed that the child can benefit from placement in a MHS special class program, arrangements are made which give him access to the special education benefits of this program without removing him from all his regular classes. By maintaining him, as much as possible, in the mainstream of regular school activities, the child is not "locked into a deviant role" (Schafer, 1967) and his re-entry into a normal role is made less difficult.

Some of the children referred for service have problems of such intensity and complexity, so far beyond the resources of the school, that the school may find it is functioning in an inappropriate custodial role. The scarcity or near-absence of treatment facilities in the community for these children has received considerable attention from the MHS staff. Efforts have begun, and will continue, to communicate a sense of urgency about the desperate need for additional services to responsible segments of the community, and to plan with them for constructive community programs.

When it was learned that approximately one-third of the elementary school children referred for service were referred because of suspected perceptual-motor dysfunction or possible minimal brain damage, another special consultant was added to the staff. His preliminary findings, in screening the special class population, show a high incidence of perceptual-motor deficits among these children. In planning for their remediation, the MHS program is integrating another theoretical orientation into its program.

The team approach, or multi-discipline approach is certainly not new. It would seem to be a requirement for developing any program designed to cope with the complexities involved in a school mental health program. The difficulties of integrating and articulating the various disciplines, however, are formidable. The MHS program has avoided the most common construction seen in school mental health programs, a pyramid of staff with the psychiatrist at the top and the teachers at the bottom. Each of the disciplines has its own unique contribution and is accorded its share of attention, recognition and respect. Simply assembling a varied staff, which speaks a variety of professional languages, does not automatically produce a cohesive team approach.

The selection of the appropriate theoretical bases to apply to the solution of social problems is a starting-point, an important consideration, to be sure, since it will determine the nature and delivery of services, but the effort must be extended into the establishment of effective inter-relationships among the various theories and their implementation.

REFERENCES

Coleman, J.V. "Social Factors Influencing the Development and Containment of Psychiatric Symptoms" in Mental Illness and Social Processes. p. 165

Frank, J.D. "The Dynamics of the Psychotherapeutic Relationship" in Mental Illness and Social Processes p.169

Health and Welfare Assn. of Allegheny County. Report of the Committee on Services for Emotionally Disturbed Children. February 1967. p.10.

Schafer, W.E. "Deviance in the Public School", in Behavioral Science for Social Workers, p.52, p.57.

Scheff, T.J. Mental Illness and Social Processes, New York: Harper & Row, 1967.

Thomas, E.J. (ed.) Behavioral Science for Social Workers. New York: The Free Press, 1967.

Vinter, R.D. and Sarri, Rosemary C. "Malperformance in the Public School: A Group Work Approach."in Behavioral Science for Social Workers, p. 354.

"...WHILE ROME BURNS..."

A Study of the Troubled Children in Our Community

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PREFACE

This brief but intense report by Vivien Richman describes, with feeling, the children we see every day. Their plight is grim, and our facilities for helping them are few and overloaded. The desert travels of these children in search of shelter and sustenance are not caused mainly by the indifference or callousness of the adult world. However, to the child who finds no help, it feels like indifference.

What these studies show is the deficits in child-care, the deadly slowness of response to cries for help, and the need for much improvement in communication among agencies, including the schools.

We, in the school system, are not entitled to cast blame on the other overworked child care institutions...we fail children too, even when trying not to. But we can and should call upon all the other agencies to find better ways to help troubled children, to let each other know what our limits are, and to be publicly honest about the areas of service that are needed.

It is in that spirit that I recommend this report, for it was written to arouse our energies and compassion in behalf of our children.

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As of February 1968, there were 64 children who were excused from attending the Pittsburgh Public Schools for psychiatric reasons. Twenty-eight of these medical excusals were requested by the Division of Mental Health Services (twelve during the school year 1966-1967, and an additional sixteen since then), and thirty-six were signed by other psychiatrists in the community. The children ranged in age from 8 to 17 years old, and included 37 boys and 27 girls.

Using the incidence rate reported in the professional literature of approximately three-fourths of one percent for psychosis or severe mental illness among children, it can readily be seen that almost 800 children in the Pittsburgh Public Schools would be expected to fall into that category. The 64 children who have been identified, therefore, may well represent less than ten percent of those who will need institutional placement or intensive psychiatric treatment.

Further, it can be expected that between 10 percent and 25 percent of the children in the Pittsburgh Public Schools will demonstrate emotional problems or social maladjustment. Applying this estimate to the population of the Pittsburgh Public Schools, we should be prepared to provide service to perhaps 12,000 children who will need help. An even more accurate appraisal would include all parochial and private school children and all the children in the Allegheny County Public Schools, since they too draw upon the scarce or almost non-existent mental health services in the community. For example, there are no in-patient psychiatric facilities in the County for children under the age of 15.

The Division of Mental Health Services has been involved in attempting to deliver services to children who demonstrate a very wide range of problems and needs. Not only is the MHS staff concerned with psychosis and mental illness, but also with all of the complex urban social problems which are vividly reflected in our school population. Obviously, a mental health staff consisting of one full-time psychiatrist-director, two part-time psychiatrists, a program coordinator, four social workers, a research associate, an instructional supervisor and 17 teachers can scarcely be expected to provide a sufficiently broad range of services in proportion to the magnitude and complexity of the problems presented.

While the public school, because of compulsory attendance laws, stands as a major public health and mental health agency in the community, it cannot be expected to accomplish these tasks alone. Its mandated function is the education of all children, gifted or handicapped, able or disabled. However, when the school identifies a child with severe emotional, social and educational problems who requires more service than the school is equipped to provide, it must turn to the community and its various social agencies.

Too frequently, in such cases, the community resources have proven to be either indifferent, reluctant, inadequate, or non-existent, leaving the school with the equally undesirable alternatives of continuing an inappropriate and, often, impossible custodial situation or issuing a medical excusal.

The Mental Health Services, during the past three years, has been immersed in the social problems of the community, as they are represented in the schools. Because of the unique position of the schools, they possess a wider perspective than that of a voluntary social agency with its self-selected population. Children, desperately and urgently in need of help, are going unheeded and unattended. Social agencies send families into circular routes of referrals and diagnostic evaluations, and when no service is available, they play the game of "place the blame", instead of mutually recognizing that the absence of adequate child-caring facilities is a crucial problem shared by all.

A very brief look at local history may help explain how this community arrived at its present state. Private social welfare agencies, such as Family Service, the Children's Aid Society and the Children's Service Bureau were replaced by the present Family and Children's Service. The Allegheny

County Juvenile Court, for many years, was the sole public agency providing care and placement for dependent and neglected children, as well as delinquents.

After World War II, the Health and Welfare Association of Allegheny County became interested in the establishment of Child Welfare Services. The Health and Welfare Association and the Community Chest wanted to establish a broad-based service agency to care for dependent and neglected children, in order to avoid duplication and for purposes of economy. One result of this has been the elimination of direct service agencies which provided custodial and protective care for children and young adults.

A number of child-caring facilities have since been discontinued...St. Joseph's Protectory for Boys, Eudes Institute, a home on Troy Hill, the Shadyside Boys' Club, the Termon Avenue Home and others, thus reducing the already inadequate number of possible placements for children.

Allegheny County planned to establish the Child Welfare Services program to replace the institutional and foster home programs which had been operated by the Juvenile Court. Child welfare legislation was passed which was to provide more adequate State reimbursement to the County. The County program, however, did not meet all State requirements and, therefore, was not eligible for full state support.

At the present time, Juvenile Court may intervene directly only if a child has been found to be sufficiently delinquent. Child Welfare Services, which is responsible for the dependent and neglected child, has neither the staff, the legal power, nor the placement facilities to serve the children who are desperately in need of help.

The few existing child care facilities are full, with long waiting lists, and many are very selective about the type of children who can be admitted. Children with a history of emotional or social problems, and children of parents found to be unworkable are frequently not admitted to the very residential care they need. Ironically, it is frequently suggested to the MHS, when no residential agency will accept them, that these disturbed and disturbing children, therefore, be retained in the school!

The cost of the human waste of children's lives is incalculable, and the waste itself is both immoral and inhuman. The present state of affairs can be most eloquently documented by the case histories presented in this report. The tragic children described here bear silent witness to their bitter plight and our collective responsibility.

The week before Christmas 1966, Danny found himself overwhelmed with despair. His life with his widowed, 54-year old illiterate, alcoholic mother was too painful, pointless and devoid of hope. He would be better off dead, he thought. He was ten years old.

The previous summer, he had tried to throw himself from a bridge. This time, he took a razor blade, slashed himself across the stomach and arrived, bleeding, in the school yard. School officials acted immediately and rushed him to a near-by hospital. They insisted that his reluctant, rather unconcerned mother accompany them to the Emergency Room, where Danny was given eleven stitches. The hospital was not equipped to provide any further treatment. No referral was made, either to Juvenile Court or to any psychiatric service, and Danny was released to return home with his mother.

The Division of Mental Health Services was contacted by the school, and, the next day, Danny and his mother were interviewed by a MHS psychiatrist and social worker. The psychiatrist found that Danny was on the brink of a psychotic depression. His mother was barely able to care for herself.

Fearing another suicide attempt, the MHS staff made an emergency referral to Juvenile Court and Danny was picked up later that day. He spent the next several months in the Child Welfare Services' Fleming Avenue Shelter, until a place was found for him at the Holy Family Institute. No psychiatric care was or is available to Danny.

Danny was one of the lucky ones. He was one of 65 children who was referred to the Mental Health Services because of suicide attempts or threats during the school year 1966-1967. They ranged in age from eight to sixteen. Twenty-two were elementary school children and 43 were high school students. This represents, of course, only those suicidal children who were brought to the attention of the Mental Health Services. The total incidence rate is not known. It is widely suspected that many traffic deaths of children are, in fact, suicidal.

Emergency facilities in the community for dealing with juvenile suicide attempts are grossly inadequate and even temporary protective facilities are very scarce. According to Dr. Stonewall B. Stickney, Director of Mental Health Services, current public philosophy, policy and practice regarding juvenile suicides are either absent or ill-informed.

The public schools are charged, by law, with the responsibility of containing and educating all the children of the community. There are many, like Danny, who desperately need much more than the schools can now provide. The Health and Welfare Association of Allegheny County, in their report, "Focus on Emotionally Disturbed Children," published in

February 1967, estimated that there are at least 27,000 children in Allegheny County between the ages of 5 and 18 who are emotionally disturbed, and an additional 12,000 children below the age of five who may have emotional problems.

Fewer than five percent of these children received any treatment at all. Danny could be counted as part of this more fortunate population.

Who are the children for whom our community offers nothing, or close to nothing?

Jimmy, a 12-year old fifth grade boy was referred to the Mental Health Services in May 1966 because of his violent, uncontrollable rages. He would scream, "I'll kill you!" and when the storm had subsided, he would burst into tears.

The boy's step-father was brutal and rejecting and the mother was ineffectual in her attempts at managing the child. The family was referred to the Child Guidance Center by the MHS, and arrangements were made for Jimmy to attend day camp during the summer with a male counselor who could provide him with some positive experiences.

In September 1966, the boy was referred to MHS again because of his continued violent behavior in school. At the

MHS conference, it was agreed that Jimmy should be placed away from home, if possible. The school social worker began to work with the family around this plan. A month later, Jimmy was suspended from school for being in a vicious fight in the school building. He was in such a terrible rage that it required three adults to separate him from the child he was attacking.

Efforts to place him were intensified, and the step-father was reported as being willing to contribute $50 a month toward the cost of his placement. By November, the school could no longer contain him, and he was given a medical excusal.

The Child Guidance Center described Jimmy as a child who could hurt himself and others, and who was desperately in need of a placement. The following "odyssey of a referral for placement" is, unfortunately, representative of the style in which our community responds to an anguished cry for help.

1. Pressley House had no room for Jimmy.
2. Friendship School in Scranton, Pa. turned the application down because they could not work with Jimmy's mother and step-father.
3. Toner Institute said that they could not contain a boy "of this type."

4. Beaver County Children's Home believed that they could not contain Jimmy.
5. Western State School and Hospital was full, with a two-year waiting list.
6. Child Guidance Center referred the family to the Western Diagnostic and Evaluation Center who, in turn, referred them to Juvenile Court.
7. The Juvenile Court stated that he was not delinquent, but was dependent and neglected, despite reports that Jimmy had broken many windows in the community.
8. Juvenile Court referred the family to Child Welfare Services who, in turn, referred them back to Western Diagnostic and Evaluation Center.
9. Western Diagnostic and Evaluation Center did not view Jimmy's situation as an emergency, in need of hospitalization.
10. Juvenile Court advised the school that a referral should be made to Child Welfare Services.
11. In February 1967, Child Welfare Services stated that they could neither place Jimmy nor offer the family the intensive case work help needed.

In July 1967, Jimmy was seen by a MHS psychiatrist who, again, strongly urged that Jimmy be placed away from his home.

In December, another medical excusal from school was issued for an indefinite period, and the parents were advised to press the issue with Juvenile Court.

Today, almost two years after his first referral to the Mental Health Services, Jimmy can see no escape from his wretched home situation, in the midst of a community which is either unaware of him, indifferent or helpless.

Sally does not know who she is. She is twelve. She tells her school mates that her male teacher is really her father. There is no father in her life. The parochial school she was attending released her because of her inappropriate behavior, and she arrived at the public school to which she was transferred in a state of confusion, anxiety and disorientation.

Sally lives with her mentally-ill mother who has been in and out of St. Francis Hospital, her maternal grandmother who is also confused and disturbed, and a 16-year old brother who is about to marry a pregnant 14-year old girl. Sally represents the third generation in a psychotic family, which has been transmitting their sickness to her, as surely as if it were smallpox or tuberculosis.

The MHS urged that residential care be found for Sally, and referred the family to Child Welfare Services and to St. Francis Hospital. Sally is out of school on a medical excusal and has embarked on her "odyssey", searching for some one, some place which will help her to find out who she is; searching for some place where she can learn how to live as a normal twelve-year old girl.

The elementary school principal became increasingly alarmed as she received reports about 12-year old Cindy's promiscuous sexual activities with boys in the sixth grade and with older boys from a neighboring high school. Her home situation was described as being sexually permissive and provocative. Maternal care and guidance have been minimal and her relationship with her father, when he was in the home, has been brutal and rejecting. Her unmarried, 16-year old sister is pregnant.

Cindy's sexual activities are advanced, and, at times, involve prostitution, mostly during the daytime. Her mother, therefore, claims that she cannot control Cindy by keeping her in the house at night.

Cindy is suspected of having acute gonorrhea. The Mental Health Services was contacted for consultation. The MHS staff believed that the school could neither hold Cindy nor help her, and strongly recommended placement in a residential school. She was given a medical excusal in November 1967. A petition was filed by the school social worker with Juvenile Court, but the Court refused to accept the referral.

Cindy is still in the streets.

William is angry at the whole world. He comes from a very large, disorganized family, dominated by angry parents who fight with each other and frequently separate. When his father is home, he is harsh and brutal to everyone.

William was referred to Mental Health Services because of his hyperactivity, aggressiveness and uncontrollable rages which occurred both in school and at home. He was suspended from school for threatening a teacher. When he was re-admitted to school, he was transferred to another elementary school, on a part-time basis. Even with the reduced pressure of a half-day schedule, and the special support provided by his placement in an adjustment class, William could neither conceal his anger nor control his aggressive behavior during the school day. The school simply was not equipped to contain him.

The MHS psychiatrist strongly suspected that William's family was squeezing him out of his home, and that William, himself, was desperately trying to remove himself from an impossible home situation. Even if the school could contain him, and it apparently could not, there was considerable question about continuing to collaborate in maintaining him in this home.

The boy was given a medical excusal and the family was referred to the Child Guidance Center for further help. Child Guidance Center evaluated the situation and found that the parents were unworkable. William, therefore, was not eligible for treatment by them. His behavior in the community worsened, until he was picked up for stealing and other delinquent activities.

His parents have separated again. His mother is experiencing great difficulty in managing William and his older brother. She has just given birth to her twelfth child, while William is still at home, awaiting placement by Juvenile Court.

Based on the evidence gathered by three years of experience in the Pittsburgh Public Schools, the Division of Mental Health Services urges swift, concerted action on the part of all concerned segments of our community...the schools, the public and voluntary social agencies, Juvenile Court, and other policy-makers at the city, county and state levels.

It is clear, even from the few grim illustrations presented in this report, that high priority must be given to the creation or expansion of a range of services and facilities for our troubled children.

The school must support and expand the present Mental Health Services program which, according to the research, shows great promise as an effective and economical utilization of scarce mental health professionals. The 17 adjustment class and resource room programs represent only a beginning. There are many schools in the city which need and want more than the crisis consultations they have received from Mental Health Services. Additional adjustment class and resource room programs will also require more special teachers, aides, psychiatrists and social workers.

In addition, the school must broaden its effort to provide more in-service education in mental health for all levels of school personnel.

The establishment of a residential school, or schools, for severely disturbed children or for children from disturbed homes, such as the Shallcross School in Philadelphia or the Project Re-Ed Schools in Tennessee should be given serious consideration.

All children entering school, at either the kindergarten or the pre-primary levels, should be screened for all exceptionalities, and appropriate remedial or habilitation programs must be developed for them, so that they may receive the full benefit of education. This would be an important preventive activity.

Since the school is already a major case-finding agency, perhaps funds from the recent legislation concerning mental retardation and mental health can be directed to the school, to enable it to fulfill this responsibility.

The community must establish emergency centers for juvenile suicides and other critical situations. Residential, protective, custodial care must be provided for the dependent and neglected child. In-patient psychiatric treatment facilities must be developed for young children, and expanded for adolescents.

These are some of our imperatives. Neither the school nor the community alone can begin to solve the problems outlined here. A massive, cooperative effort is urgently required, free from inter-agency squabbles, cutting across disciplines and traditional agency boundaries, with an unwavering focus on meeting the needs of the troubled child.

The children described in this report are some of our mental health statistics come to life. We are often more inclined to deal with numbers and statistics because they are cool, objective and neutral, and do not cause us embarrassment or shame. But these are our children, unprotected, defenseless, unrepresented, and deeply wounded.

Who will speak for them?